

# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information

**A. The State of Iowa** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

**B. Program Title:**

**The Children's Mental Health Waiver**

**C. Waiver Number: IA.0819**

**D. Amendment Number: IA.0819.R02.01**

**E. Proposed Effective Date:** (mm/dd/yy)

04/01/20

**Approved Effective Date: 04/01/20**

**Approved Effective Date of Waiver being Amended: 10/01/18**

### 2. Purpose(s) of Amendment

**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:

The purpose of this amendment is to make the following revisions to Performance Measures:

1. Designate those PMs where data is stratified across all Iowa 1915(c) waivers. Include language to clarify the use of stratified data. These changes affect specific measures in Appendix B, D and G.
2. Revise the language of PM QP-a1 and QP-a2 in accordance with direction from CMS through the recent Iowa Brain Injury Waiver renewal.
3. Add 2 new performance measures: QP-a2 and QP-b3 in accordance with direction from CMS through the recent Iowa Brain Injury Waiver renewal.
4. Answered App H-2-a as required for validation.

### 3. Nature of the Amendment

**A. Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A Waiver Administration and Operation	
Appendix B Participant Access and Eligibility	LC-C1
Appendix C Participant Services	QP-a1, QP-a2, QPb3
Appendix D Participant Centered Service Planning and Delivery	All Performance Measures
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	HW-c1
Appendix H	H-1:a-i, H-2-a
Appendix I Financial Accountability	
Appendix J Cost-Neutrality Demonstration	

**B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)**
  - Modify Medicaid eligibility**
  - Add/delete services**
  - Revise service specifications**
  - Revise provider qualifications**
  - Increase/decrease number of participants**
  - Revise cost neutrality demonstration**
  - Add participant-direction of services**
  - Other**
- Specify:

Revisions to performance measures

# Application for a §1915(c) Home and Community-Based Services Waiver

## 1. Request Information (1 of 3)

**A. The State of Iowa** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (optional - this title will be used to locate this waiver in the finder):

The Children's Mental Health Waiver

**C. Type of Request:** amendment

**Requested Approval Period:**(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

3 years      5 years

**Waiver Number:**IA.0819.R02.01

**Draft ID:**            IA.013.02.01

**D. Type of Waiver** (select only one):

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended:** 10/01/18

**Approved Effective Date of Waiver being Amended:** 10/01/18

## 1. Request Information (2 of 3)

**F. Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (check each that applies):

### Hospital

Select applicable level of care

#### Hospital as defined in 42 CFR §440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

#### Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

### Nursing Facility

Select applicable level of care

#### Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

#### Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

### Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

---

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

**Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Iowa High Quality Healthcare Initiative

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

**§1915(b)(1) (mandated enrollment to managed care)**

**§1915(b)(2) (central broker)**

**§1915(b)(3) (employ cost savings to furnish additional services)**

**§1915(b)(4) (selective contracting/limit number of providers)**

**A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

**A program authorized under §1915(i) of the Act.**

**A program authorized under §1915(j) of the Act.**

**A program authorized under §1115 of the Act.**

*Specify the program:*

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

**This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

---

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The goal of the Iowa HCBS Children's Mental Health (CMH) waiver is to provide community alternatives to institutional services. Through need-based funding of individualized supports, eligible members may maintain their position within their homes and communities rather than default placement within an institutional setting. The Iowa Department of Human Services (DHS) Iowa Medicaid Enterprise (IME) is the single state agency responsible for the oversight of Medicaid.

Individuals access waiver services by applying to their local DHS office or through the online DHS benefits portal. Each individual applying for waiver services must meet hospital facility level of care (i.e., inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160). IME's Medical Services Unit (MSU) is responsible for determining the initial level of care decisions for all applicants, and level of care reevaluations for fee-for-service members. MCOs are responsible for conducting level of care reevaluations for their members, with IME having final review and approval authority for all reassessments that indicate a change in the level of care. Further, the MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. In the event there is a waiting list for waiver services at the time of initial assessment, applicants are advised of the waiting list and that they may choose to receive facility-based services.

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

Services include environmental modifications and adaptive devices; family and community supports; in-home family therapy; and respite.

Through increased legislative focus of appropriations, mental health and disability services redesign, and infrastructure development through Iowa's Balancing Incentives Payment Program, it is the goal of Iowa to offer a more uniform and equitable system of community support delivery to individuals qualifying for waiver services.

### 3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

**Yes. This waiver provides participant direction opportunities.** Appendix E is required.

**No. This waiver does not provide participant direction opportunities.** Appendix E is not required.

- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the state makes payments for waiver services,

ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration.** Appendix J contains the state's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

---

**A. Comparability.** The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

**Not Applicable**

**No**

**Yes**

**C. Statewide.** Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

**No**

**Yes**

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

**Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

**Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state. *Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

#### 5. Assurances

---

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

**A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

---

*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in

the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

DHS seeks continuous and ongoing public input through a variety of committees and organizations. Specifically, the Mental Health Planning Council meets monthly and provides input as necessary. DHS has appointed one staff person from the IME Long Term Care Unit to the Council, which includes various stakeholders including participants and families, providers, case managers, and other State departments. IME is also invited to attend a number of association and advocacy group meetings (i.e., Iowa Association of Community Providers, Iowa State Association of Counties, Iowa Health Care Association, and Olmstead Task Force) to provide and seek feedback on service planning, cost reporting, quality assurance documentation requirements, and case management issues.

The public has the opportunity to comment on Iowa Administrative rules and rule changes through the public comment process, the Legislative Rules Committee, and the DHS Council. The IME also provides notice of applications and amendments by including notice in the IME e-News emails and on the IME website.

IME used the following processes to secure public input into the development of the Waiver Renewal Application:

- 1) IME Website Posting - The public notice and the Waiver Renewal Application was posted to the DHS IME Website under the category, News & Initiatives <https://dhs.iowa.gov/public-notices/CMH-Waiver-Renewal>. The public posting period began April 6, 2018 and ended May 9, 2018. The Waiver program manager Leann Howland received no public comments during this period.
- 2) DHS Field Office Posting - IME provides notification to the DHS Field Office, which in turn, notifies each DHS Field Office to post the Waiver Public Notice and to provide a copy of the CMS Waiver Renewal Application for any public request. The public posting period was the same for this process. The Waiver program manager Leann Howland receive no public comments.
- 3) IME Public Notice Subscribers - Medicaid members, Medicaid providers, legislators, advocacy organizations and others who wish to remain informed regarding Iowa Medicaid can subscribe to the IME Public Notice webpage. All subscribers will receive electronic notice whenever an update/public notice is posted. This process includes HCBS waiver renewals. The public posting period was the same for this process. The Waiver program manager Leann Howland receive public comments.
- 4) Iowa Tribal Nations Notification - The IME Tribal Nations liaison notified all Nation governments by email on April 9, 2018. The comment period ended on May 9, 2018. The liaison Leann Howland received no comments or questions during this period. Update: Iowa misunderstood the need for verbal notification of a 30 day comment period prior to email notification. On May 25, 2018 the IME made telephone contact with the tribes to indicate that comments would be accepted through June 16, 2018. This allowed the tribes to submit comments for more than 60 days after their first notification. No comments were received during this time period.

**J. Notice to Tribal Governments.** The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

Howland

**First Name:**

Leann

**Title:**

Program Manager

**Agency:**

Iowa Department of Human Services

**Address:**

100 Army Post Road

**Address 2:**

**City:**

Des Moines

**State:**

Iowa

**Zip:**

50315

**Phone:**

(515) 256-4642

Ext:

TTY

**Fax:**

(515) 725-1360

**E-mail:**

lhowlan@dhs.state.ia.us

**B.** If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:**

Iowa

**Zip:**

**Phone:**

Ext:  TTY

**Fax:**

**E-mail:**

**8. Authorizing Signature**

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

**Signature:**

State Medicaid Director or Designee

**Submission Date:**

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** Iowa

**Zip:**

**Phone:**  Ext:  TTY

**Fax:**

E-mail:

**Attachments**

mrandol@dhs.state.ia.us

**Attachment #1: Transition Plan**

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

**Replacing an approved waiver with this waiver.**

**Combining waivers.**

**Splitting one waiver into two waivers.**

**Eliminating a service.**

**Adding or decreasing an individual cost limit pertaining to eligibility.**

**Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

**Reducing the unduplicated count of participants (Factor C).**

**Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

**Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

**Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Total unduplicated number of members were trended to remain the same throughout the five years of the waiver. Unduplicated members were based on the assumptions provided by the actuary and historical trends. The projections used in the last amendment were not realized. The reduction in the number of unduplicated members will not cause any member to lose waiver eligibility as the waiver has never reached even this lower number.

Limitation on the Number of members Served at any Point in Time were projected to remain the same each year based on historical growth and average monthly costs per member on the waiver. The members served will not cause any member to lose waiver eligibility as the waiver has never reached even this lower number.

All members participating under this waiver prior to the renewal will continue to participate with the waiver, as long as those members continue to meet eligibility criteria at their next annual reviews.

Implementation of the decreased unduplicated number of members and Number of members served at one time will be implemented on paper only, as the state has not actually reached the current numbers. No members will be affected by these changes, so there is no implementation that affects persons.

Health and Welfare of all members enrolled in this waiver are assured through the Performance Measures included in this renewal as well as the processes outlined in this renewal.

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter*

08/26/2020

"Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

## Appendix A: Waiver Administration and Operation

**1. State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

**The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

**The Medical Assistance Unit.**

Specify the unit name:

Bureau of Long Term Care, the Iowa Medicaid Enterprise (IME)

(Do not complete item A-2)

**Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

**The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

## Appendix A: Waiver Administration and Operation

**2. Oversight of Performance.**

**a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the

methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

**b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

---

**3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

MCOs will be responsible for delivering covered benefits, including physical health, behavioral health and LTSS in a highly coordinated manner. Specific functions include, but are not limited to, the following:

- Developing policies and procedures for ongoing identification of members who may be eligible for waiver services;
- Conducting needs assessments, developing service plans, coordinating care, and authorizing and initiating waiver services;
- Conducting LOC reassessments with IME retaining final review and approval authority for any reassessments which indicate a change in the LOC;
- Delivering community-based case management services and monitoring receipt of services;
- Maintaining a toll-free telephone hotline for all providers with questions, concerns, or complaints;
- Maintaining a toll-free telephone hotline for all members to address questions, concerns, or complaints;
- Operating a 24/7 toll-free Nurse Call Line to provide nurse triage telephone services
- Creating and distributing member and provider materials (handbooks, directory, forms, policies and procedures, notices, etc.);
- Operating an incident reporting and management system;
- Maintaining a utilization management program;
- Developing programs and participating in activities to enhance the general health and well-being of members; and
- Conducting provider services such as network contracting, credentialing, enrollment and disenrollment, training, and claims processing.

#### FFS

Those members who have not made an MCO selection, or who are otherwise ineligible for managed care enrollment as defined in the §1915(b) waiver, will continue to receive services through the FFS delivery system. Iowa does not automatically assign new members to an MCO; they are sent an MCO choice packet at the time they are found Medicaid eligible. The packet indicates a future MCO enrollment date. If the MCO choice deadline passes without the member making an MCO choice, then the member will become enrolled with the MCO identified in the choice notification from the IME. The notice includes the effective date of MCO enrollment, regardless of whether or not a choice was made by the member. Failure by the member to make an MCO choice does not cause the member to remain FFS.

The State will continue to contract with the following entities to perform certain waiver functions.

Member Services (Maximus) as part of a contract with IME to disseminate information to Medicaid members and provide member support. This Unit provides clinical review in effort to identify member population risks such that additional education, program support, and policy revision can mitigate risks to the member when possible.

Medical Services (Telligen) as part of a contract with the IME conducts level of care evaluations and service plan development ad-hoc reviews to ensure that waiver requirements are met. The IME MSU conducts the necessary activities associated with prior authorization of waiver services, authorization of service plan changes and medical necessity reviews associated with Program Integrity and Provider Cost Audit activities.

Home and Community Based Quality Assurance (Telligen) as part of a contract with the IME reviews provider compliance with State and federal requirements, monitors complaints, monitors critical incident reports and technical assistance to ensure that quality services are provided to all Medicaid members.

Program Integrity and Recovery Audit Coordinator (Optum) as part of a contract with the IME reviews provider records and claims for instances of Medicaid fraud, waste, and abuse. These components are evaluated and analyzed at an individual and system level through fraud hotline referrals and algorithm development.

Provider Services (Maximus) as part of a contract with the IME coordinates provider recruitment and executes the Medicaid Provider Agreement. The Provider Services Unit conducts provider background checks as required, conducts annual provider trainings, supervises the provider assistance call center, and manages the help functions associated with the IME's Individualized Services Information System (ISIS).

Provider Cost Audit (Myers and Stouffer) as part of a contract with the IME determines service rates and payment amounts. The Provider Cost Audit Unit performs financial reviews of projected rates, reconciled cost reports, and performs onsite fiscal reviews of targeted provider groups.

Revenue Collections Unit (HMS), as part of a contract with the IME, performs recovery of identified overpayments related to program integrity efforts, cost report reconciliations, third-party liability, and trusts.

Pharmacy (Gould Health Systems), as part of the contract with IME, this unit oversees the operation of the Preferred Drug List (PDL) and Prior Authorization (PA) for prescription drugs. The development and updating of the PDL allows the Medicaid program to optimize the funds spent for prescription drugs. The Pharmacy Medical group performs drug Prior Authorization with medical professionals who evaluate each request for the use of a number of drugs.

Point-of-Sale (POS) (Gould Health Systems), as part of the contract with the IME, this is the pharmacy point of sale system. It is a real-time system for pharmacies to submit prescription drug claims for Iowa Medicaid beneficiaries and receive a timely determination regarding payment.

All contracted entities including the Medicaid Department conduct training and technical assistance concerning their particular area of expertise concerning waiver requirements. Please note that ultimately it is the Medicaid agency that has overall responsibility for all of the functions while some of the functions are performed by contracting agencies. In regards to training, technical assistance, recruitment and disseminating information, this is done by both the Medicaid agency and contracted agencies throughout regular day-to-day business.

**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

**4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

**Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

**Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

**5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

IME Medical Policy Staff, through DHS, is responsible for oversight of the contracted entities. The DHS IME is the State Agency responsible for conducting the operational and administrative functions of the waiver.

## Appendix A: Waiver Administration and Operation

**6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

IME is an endeavor that unites State Staff and "Best of Breed" contractors into a performance-based model for the administration of the Iowa Medicaid program. The IME is a collection of specific units, each having an area of expertise, and all working together to accomplish the goals of the Medicaid program. Housed in a single building, the IME has contract staff who participates in the following activities: provider services, member services, provider audit and rate setting, processing payments and claims, medical services, pharmacy, program integrity, and revenue collections. All contracts are selected through a competitive request for proposal (RFP) process. Contract RFPs are issued every five years.

All contracted entities are assigned a State-employed contract manager, are assessed through their performance-based contracts, and are required to present their performance on contract standards at a monthly meeting to the Medicaid Policy Staff. Monthly meetings are designed to facilitate communication among the various business units within the IME to ensure coordination of operations and performance outcomes. Further, non-MCO contracted entities and Medicaid Policy staff are located at the same site, which limits the barriers of routine management and oversight. In addition, all contracted agencies are required to complete a comprehensive quarterly report on their performance to include programmatic and quality measures designed to measure the contract activities as well as trends identified within Medicaid programs and populations.

The State has established a MCO Oversight and Supports Bureau within IME to provide comprehensive program oversight and compliance. Specifically, the Bureau Chief, reporting directly to the Medicaid Director, is responsible for directing the activities of bureau staff. Each MCO account manager will oversee contract compliance for one designated MCO. The MCO account managers will serve as liaisons between the MCOs and the State, and will be the point of contact coordinating communications and connecting subject matter experts. The new Bureau will work directly with the IME Program Integrity Unit, which oversees compliance of all IME providers, including the MCOs.

## Appendix A: Waiver Administration and Operation

**7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care evaluation		

Function	Medicaid Agency	Contracted Entity
Review of Participant service plans		
Prior authorization of waiver services		
Utilization management		
Qualified provider enrollment		
Execution of Medicaid provider agreements		
Establishment of a statewide rate methodology		
Rules, policies, procedures and information development governing the waiver program		
Quality assurance and quality improvement activities		

**Appendix A: Waiver Administration and Operation**

**Quality Improvement: Administrative Authority of the Single State Medicaid Agency**

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

**a. Methods for Discovery: Administrative Authority**

*The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*

**i. Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

*Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**AA-1: IME shall measure the number and percent of required MCO HCBS PM quarterly reports that are submitted timely. Numerator = # of HCBS PM quarterly reports submitted timely; Denominator = # of MCO HCBS PM quarterly reports due in a calendar quarter.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**MCO performance monitoring**

<b>Responsible Party for data</b>	<b>Frequency of data</b>	<b>Sampling Approach</b> (check
-----------------------------------	--------------------------	---------------------------------

<b>collection/generation</b> ( <i>check each that applies</i> ):	<b>collection/generation</b> ( <i>check each that applies</i> ):	<i>each that applies</i> :
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="MCOs"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**Performance Measure:**

**AA-2: The IME shall measure the number and percent of months in a calendar quarter that each MCO reported all HCBS PM data measures. Numerator = # of months each MCO entered all required HCBS PM data; Denominator = # of reportable HCBS PM months in a calendar quarter.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MCO performance monitoring**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<p><b>Representative Sample</b> Confidence Interval =</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; padding: 5px;">MCOs</div>	<b>Annually</b>	<p><b>Stratified</b> Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Other</b> Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Through the Bureau of Managed Care each MCO is assigned state staff as the contract manager; and other state staff are assigned to aggregate and analyze MCO data. This staff oversees the quality and timeliness of monthly reporting requirements. Whenever data is late or missing the issues are immediately addressed by each MCO account manager to the respective MCO.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

If the contract manager, or policy staff as a whole, discovers and documents a repeated deficiency in performance of the MCO, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of payment compensation.

General methods for problem correction include revisions to state contract terms based on lessons learned.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text" value="Contracted Entity and MCOs"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix B: Participant Access and Eligibility**

**B-1: Specification of the Waiver Target Group(s)**

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<b>Aged or Disabled, or Both - General</b>					
		Aged	<input type="checkbox"/>	<input type="checkbox"/>	
		Disabled (Physical)	<input type="checkbox"/>	<input type="checkbox"/>	
		Disabled (Other)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
		Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	
		HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
		Medically Fragile	<input type="checkbox"/>	<input type="checkbox"/>	

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Technology Dependent			
<b>Intellectual Disability or Developmental Disability, or Both</b>					
		Autism			
		Developmental Disability			
		Intellectual Disability			
<b>Mental Illness</b>					
		Mental Illness			
		Serious Emotional Disturbance	0	17	

**b. Additional Criteria.** The state further specifies its target group(s) as follows:

Must have a diagnosis of serious emotional disturbance (SED), defined as a diagnosable mental, behavioral, or emotional disorder that: (1) is of sufficient duration to meet diagnostic criteria for the disorder specified in the Diagnosis and Statistical Manual of Mental Disorders, fifth edition, (DSM-V) published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a member’s role or functioning in family, school, or community activities. SED shall not include developmental disorders, substance-related disorders, or conditions or problems classified in the DSM-V as other conditions that may be a focus of clinical attention” (V Codes), unless these conditions co-occur with another diagnosable serious emotional disturbance. Psychological documentation that substantiates a mental health diagnosis of SED as determined by a mental health professional must be current within the 12-month period before the application date.

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

**Not applicable. There is no maximum age limit**

**The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

Members, upon reaching the age of 18, may transition into adult mental health services, as appropriate, to meet their identified needs. Iowa has an approved 1915(i) waiver called the HCBS Habilitation Services. Habilitation Services is a program to provide HCBS to Iowans with the functional impairments typically associated with chronic mental illnesses. Habilitation Services are designed to assist members in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Services available through the program include case management, home based habilitation, day habilitation, prevocational services and supported employment. HCBS Habilitation Services, like the CMH Waiver services, are provided in a variety of integrated community-based environments.

Habilitation Services is a State Plan service available to children and adults meeting the Habilitation Services criteria. Children accessing the CMH Waiver services that will be needing services as an adult are often accessing Habilitation Services prior to turning age 18. Transition planning to adult service is done by the case manager, health home coordinator, or community-based case manager prior to, and following, the member turning 18. The Habilitation Services offers additional service options not available in the CMH Waiver. Transitional services are developed based on an assessment of need as the member moves into adult services. Some CMH Waiver members may not qualify for Habilitation Services, choose to not receive services, or choose to move out of state.

It is important to note that transition planning does occur for all CMH Waiver members who will age out of the waiver, regardless of their intent to continue services. For fee-for-service members, the State uses ISIS to remind the case manager or health home coordinator, when a CMH enrolled child reaches age 17 and that transition planning should occur. MCOs are responsible for implementing processes to notify community-based case managers.

Children with co-occurring diagnoses can apply for any other Iowa HCBS waiver that they may qualify for, as long as the co-occurring diagnoses and other eligibility criteria are met. A member can only be on one waiver at a time, so the member must choose one waiver if they are found to be eligible for more than one waiver. The choice is made by the member not the state.

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

**No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

**Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

**The limit specified by the state is (*select one*)**

**A level higher than 100% of the institutional average.**

Specify the percentage:

**Other**

*Specify:*

**Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete*

*Items B-2-b and B-2-c.*

**Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

**The cost limit specified by the state is (select one):**

**The following dollar amount:**

Specify dollar amount:

**The dollar amount (select one)**

**Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

**May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

**The following percentage that is less than 100% of the institutional average:**

Specify percent:

**Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

**Answers provided in Appendix B-2-a indicate that you do not need to complete this section.**

**b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

**c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the

participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

**The participant is referred to another waiver that can accommodate the individual's needs.**

**Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

**Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (1 of 4)

**a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1570
Year 2	1601
Year 3	1633
Year 4	1666
Year 5	1699

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: (*select one*) :

**The state does not limit the number of participants that it serves at any point in time during a waiver year.**

**The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
	1237
Year 2	1262
Year 3	1287
Year 4	1313
Year 5	1339

**Appendix B: Participant Access and Eligibility**

**B-3: Number of Individuals Served (2 of 4)**

**c. Reserved Waiver Capacity.** The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

**Not applicable. The state does not reserve capacity.**

**The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes
Mental Health Institutes (MHI), Psychiatric Residential Treatment Facility (PRTF) and out of state facility placement transition

**Appendix B: Participant Access and Eligibility**

**B-3: Number of Individuals Served (2 of 4)**

**Purpose** (*provide a title or short description to use for lookup*):

Mental Health Institutes (MHI), Psychiatric Residential Treatment Facility (PRTF) and out of state facility placement transition

**Purpose** (*describe*):

The state reserves payment slots each waiver year (July 1 - June 30) for use by members living in a state of Iowa Mental Health Institute (MHI), a Psychiatric Residential Treatment Facility (PRTF), or out of state facility placements who choose to access services in the CMH waiver program and leaves the State MHI, PRTF, or out of state placement to live within their family home. For the purpose of reserved capacity within the CMH waiver, a PRTF is defined as 442 CFR §483.352, which states: “[a] Psychiatric Residential Treatment Facility means a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting.”

The reserved capacity slots are available for use by any person eligible for this waiver program that currently resides in a state MHI, PRTF, or out of state facility placement, has lived there for at least six months, and is choosing this waiver program over institutional services to return to their family home. The member must meet the CMH waiver eligibility criteria by being assessed and meet a hospital level of care. Payment slots will be available on a first come, first served basis. The member accessing the reserved capacity payment slot shall use the slot for the remainder of the current CMH waiver year, (July 1 - June 30). At the end of the waiver year, the payment reserved capacity slot will become part of the overall payment slots approved for use within the CMH waiver. If a child returns to the state MHI, PRTF, or facility placement for more than 60 days, or loses eligibility for the CMH waiver during the current waiver year, the reserved capacity payment slot shall revert back to the reserved capacity payment slots and shall be made available for another member choosing to access the reserved capacity payment slot.

**Describe how the amount of reserved capacity was determined:**

Waiver reserve slots are approximately 1% of the total slots available within the waiver.

**The capacity that the State reserves in each waiver year is specified in the following table:**

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

**Appendix B: Participant Access and Eligibility**

**B-3: Number of Individuals Served (3 of 4)**

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

**The waiver is not subject to a phase-in or a phase-out schedule.**

**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one:*

**Waiver capacity is allocated/managed on a statewide basis.**

**Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among

local/regional non-state entities:

**f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Per Iowa Administrative Code 441-83.123(1)c, if no waiver slot is available, DHS enters applicants on the CMH waiver waiting list according to the following: “(1) [t]he names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department; (2) [t]he names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1)a [(i.e., by the end of the fifth working day after receipt of a completed Health Services Application from a non-current Medicaid member; a completed Case Management Comprehensive Assessment; or a written request); (3) [i]n the event that more than one application is received at one time, the names of applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.” As such, applicants are added to the waiting list based on date of application. This criterion is objective and does not give precedence to new applicants over current members or vice versa.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

**a. 1. State Classification.** The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

**2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

**b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

*Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)*

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

*Select one:*

100% of the Federal poverty level (FPL)

**% of FPL, which is lower than 100% of FPL.**

Specify percentage:

**Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)**

**Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

**Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

**Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

**Medically needy in 209(b) States (42 CFR §435.330)**

**Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

**Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

*Specify:*

Parents and other caretaker relatives specified at 42 CFR §435.110; pregnant women specified at 42 CFR §435.116; and children specified at 42 CFR §435.118.

---

***Special home and community-based waiver group under 42 CFR §435.217*** Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

---

**No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.**

**Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

*Select one and complete Appendix B-5.*

**All individuals in the special home and community-based waiver group under 42 CFR §435.217**

**Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

*Check each that applies:*

**A special income level equal to:**

*Select one:*

**300% of the SSI Federal Benefit Rate (FBR)**

**A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

**A dollar amount which is lower than 300%.**

Specify dollar amount:

**Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

**Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

**Medically needy without spend down in 209(b) States (42 CFR §435.330)****Aged and disabled individuals who have income at:**

Select one:

**100% of FPL****% of FPL, which is lower than 100%.**Specify percentage amount: **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

**Appendix B: Participant Access and Eligibility****B-5: Post-Eligibility Treatment of Income (1 of 7)**

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

*Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

**Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).*

*Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).*

**Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

**Use spousal post-eligibility rules under §1924 of the Act.**

*(Complete Item B-5-b (SSI State) and Item B-5-d)*

**Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

**Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

**Appendix B: Participant Access and Eligibility**

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

**b. Regular Post-Eligibility Treatment of Income: SSI State.**

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

---

**i. Allowance for the needs of the waiver participant (select one):**

---

**The following standard included under the state plan**

Select one:

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

(select one):

**300% of the SSI Federal Benefit Rate (FBR)**

**A percentage of the FBR, which is less than 300%**

Specify the percentage:

**A dollar amount which is less than 300%.**

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the state Plan**

Specify:

**The following dollar amount**

Specify dollar amount:  If this amount changes, this item will be revised.

**The following formula is used to determine the needs allowance:**

Specify:

**Other**

Specify:

The following formula is used to determine the needs allowance: 300% of the SSI benefit and for participants who have a medical assistance income trust (Miller Trust) an additional \$10 (or higher if court ordered) to pay for administrative costs.

DHS determines patient liability. Client participation is the amount that a member is required to contribute toward the cost of waiver services. To calculate client participation:

1. Determine only the member's total gross monthly income.
2. Subtract a maintenance needs allowance of 300% of the current SSI benefit for one person.
3. Add in veteran's aid and attendance and veteran's housebound allowance.

The result is the client participation amount.

4. The IMW makes client participation entries on the Automated Benefit Calculation (ABC) system. The IMW notifies the HCBS case manager of the type and amount of client participation to be paid, if any. It is a HCBS case manager's responsibility to apply the client participation toward a specific service.

For managed care enrollees with a patient liability, DHS will communicate to the MCO the amount of each member's liability. Members will be responsible for remitting their patient liability to their waiver providers. The MCO reduces its payment for a member's waiver services up to the amount of the patient liability.

The capitation rates calculated for MCOs includes a long-term services and supports (LTSS) component which is a blend of institutional services and home and community based services (HCBS). When capitation rates were developed, the LTSS component was calculated with consideration given to patient liability as a possible source of funds used to pay a portion of the services provided through the waiver. For both the institutional and HCBS component of the rate, the average patient liability was subtracted. Therefore, the MCOs are paid net of the average patient liability.

The state has develop a method to carve out/identify the cost of home and community-based waiver services from the cost of other Medicaid services so that the individual's patient liability is applied only to the cost of home and community-based waiver services.

For Fee for service members, the patient liability is carried in the HCBS ISIS system. A case manager is required to identify those HCBS services and provider combinations where patient liability will be applied and how much of the liability amount will be designated to that service. The authorized payment amount is reduced by the amount of the liability. This information is communicated to the MMIS Prior Authorization file. At the time of HCBS claim payment MMIS looks to the PA file for any HCBS service authorization limitation, including the maximum payable amount for a specific service.

One of the contracted Managed Care Organizations uses a similar process as explained above, except that the MCO's claim payment system carries the HCBS prior authorization and HCBS patient liability amounts. When the claim is submitted, the claims system identifies the authorization related to the claims and then applies HCBS patient liability amounts as authorized. This process omits any 'medical' or behavioral health claim not subject to HCBS patient liability withholding.

The other MCO utilizes edits/triggers within their claims adjudication system that are programmed to systemically only identify very specific claims perimeters that are subject to HCBS patient liability. Specific to HCBS, this is drilled down by specific procedure codes and modifier combinations that correspond to the member's eligibility enrollment type. The MCO processes HCBS patient liability on a 'first in, first out basis'. This means, if multiple providers/claims are submitted within the month, the first claim with HCBS service perimeters is subject to the patient liability withholding. If this first claim does not satisfy the full amount, the next claim received/processed would additionally be subject to patient liability withholding until the full dollar amount is satisfied for this month. This process omits any 'medical' or behavioral health claim not subject to HCBS patient liability withholding.

**ii. Allowance for the spouse only (select one):**

**Not Applicable**

**The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

*Specify:*

**Specify the amount of the allowance (select one):**

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The following dollar amount:**

Specify dollar amount:  If this amount changes, this item will be revised.

**The amount is determined using the following formula:**

*Specify:*

---

**iii. Allowance for the family (select one):**

---

**Not Applicable (see instructions)**

**AFDC need standard**

**Medically needy income standard**

**The following dollar amount:**

Specify dollar amount:  The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

**The amount is determined using the following formula:**

*Specify:*

**Other**

*Specify:*

---

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

---

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

**Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

**The state does not establish reasonable limits.**

**The state establishes the following reasonable limits**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

#### c. Regular Post-Eligibility Treatment of Income: 209(B) State.

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

#### d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

##### i. Allowance for the personal needs of the waiver participant

*(select one):*

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

**A percentage of the Federal poverty level**

Specify percentage:

**The following dollar amount:**

Specify dollar amount:  If this amount changes, this item will be revised

**The following formula is used to determine the needs allowance:**

*Specify formula:*

**Other**

*Specify:*

The following formula is used to determine the needs allowance: 300% of the SSI benefit and for participants who have a medical assistance income trust (Miller Trust) an additional \$10 (or higher if court ordered) to pay for administrative costs.

DHS determines patient liability. Client participation is the amount that a member is required to contribute toward the cost of waiver services. To calculate client participation:

1. Determine only the member's total gross monthly income.
2. Subtract a maintenance needs allowance of 300% of the current SSI benefit for one person.
3. Add in veteran's aid and attendance and veteran's housebound allowance.

The result is the client participation amount.

4. The IMW makes client participation entries on the Automated Benefit Calculation (ABC) system. The IMW notifies the HCBS case manager of the type and amount of client participation to be paid, if any. It is a HCBS case manager's responsibility to apply the client participation toward a specific service.

For managed care enrollees with a patient liability, DHS will communicate to the MCO the amount of each member's liability. Members will be responsible for remitting their patient liability to their waiver providers. The MCO reduces its payment for a member's waiver services up to the amount of the patient liability.

The capitation rates calculated for MCOs includes a long-term services and supports (LTSS) component which is a blend of institutional services and home and community based services (HCBS). When capitation rates were developed, the LTSS component was calculated with consideration given to patient liability as a possible source of funds used to pay a portion of the services provided through the waiver. For both the institutional and HCBS component of the rate, the average patient liability was subtracted. Therefore, the MCOs are paid net of the average patient liability.

**ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

**Allowance is the same**

**Allowance is different.**

*Explanation of difference:*

**iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

**Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

**The state does not establish reasonable limits.**

**The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## **Appendix B: Participant Access and Eligibility**

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.**

---

**Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.**

---

**Appendix B: Participant Access and Eligibility**

---

**B-5: Post-Eligibility Treatment of Income (6 of 7)**

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

---

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

---

**Appendix B: Participant Access and Eligibility**

---

**B-5: Post-Eligibility Treatment of Income (7 of 7)**

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

---

**Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.**

---

**Appendix B: Participant Access and Eligibility**

---

**B-6: Evaluation/Reevaluation of Level of Care**

*As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

**a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

**ii. Frequency of services.** The state requires (select one):

**The provision of waiver services at least monthly**

**Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

HCBS waiver services must be accessed at least once every calendar quarter by the member. The unit of service must be one of the four services available through the waiver (i.e., respite, family and community supports, in-home family therapy, or environmental modifications and adaptive devices).

**b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

**Directly by the Medicaid agency**

**By the operating agency specified in Appendix A**

**By a government agency under contract with the Medicaid agency.**

*Specify the entity:*

**Other**

*Specify:*

**Initial LOC decision**  
 The IME MSU is responsible for making all initial level of care decisions. If a member is not currently in Medicaid or is in FFS, the IME’s CSA contractor performs the assessment. If a member is enrolled with a MCO, the assessment is performed by the MCO. LOC decisions are also include input of from the case manager, health home coordinator, community-based case manager, medical professional, and other appropriate professionals.

**Reevaluations**  
 For fee-for-service members, the reevaluation is also conducted by the IME MSU. MCOs are responsible for reevaluations of their members. The IME MSU reviews and approves all reevaluations that indicate a change in the member’s level of care. MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. Upon identification the MCO completes the initial level of care assessment with the IME MSU maintaining final review and approval authority.

**c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Medical professionals (i.e., licensed physician, physician assistant or advanced registered nurse practitioner) perform the initial evaluation/complete the assessment tool. The IME requires that professionals completing the level of care determination are licensed RNs. If the RN is unable to approve level of care, then the Physician Assistant or MD make the final level of care determination.

**d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

All criteria outlined in this section apply to both initial and reevaluation of Level of Care.

IME Medical Services uses the interRAI Community Mental Health(CMH), or other department approved comprehensive functional assessment tool, to determine level of care. The interRAI CMH has been designed to be a user-friendly, reliable, person-centered assessment system that informs and guides comprehensive care and service planning in community-based settings around the world. It focuses on the person's functioning and quality of life by assessing needs, strengths, and preferences, and facilitates referrals when appropriate. The domain areas covered in the interRAI CMH include:

- Identification Information
- Intake and Initial History
- Mental State Indicators
- Substance Use or Excessive Behavior
- Harm to Self and Others
- Behavior
- Cognition
- Functional Status
- Communication and Vision
- Health Conditions
- Stress and Trauma
- Medications
- Service Utilization and Treatments
- Nutritional Status
- Social Relations
- Employment, Education and Finances
- Environmental Assessment
- Diagnostic Information
- Discharge
- Community Mental Health supplements

The interRAI Mental Health Supplement to the Community Health Assessment (CHA-MH) includes an expanded item set on mental health-related diagnoses, symptoms, treatments, and life experiences. The items in this supplement describe the performance and capacity of the person in a variety of domains, with the majority of items serving as specific triggers for care planning. The goal is to use this information to identify individual needs and appropriate interventions.

When used over time, it provides the basis for an outcome-based assessment of the person's response to care or services. The interRAI CMH can be used to assess persons with chronic needs for care as well as those with post-acute care needs (for example, after hospitalization)

In conjunction with the following criteria to specify a level of care:

1. Must have a mental disorder as supported by the current DSM diagnostic criteria. A diagnosis of developmental disabilities or substance abuse alone is not sufficient for involvement in the CMH waiver program. A member may have a co-occurring disability with the diagnosable mental disorder, but the level of stability and the degree of impairment (2 and 3 below) must be attributable to the mental disorder and not the co-occurring disability.
2. The member must demonstrate a risk to self and/or others but can be managed with the services available through the CMH waiver; demonstrate the ability to engage in activities of daily living but lacks adequate medical/behavioral stability and/or social and familial support to maintain or develop age-appropriate cognitive, social and emotional processes; and be medically stable but may require occasional medical observation and care.
3. The member has impairment in judgment, impulse control and/or cognitive/perceptual abilities arising from a mental disorder that indicates the need for close monitoring, supervision and intense intervention to stabilize or reverse dysfunction; and
  - a. The member demonstrates significantly impaired interpersonal functioning arising from a disorder that requires active intervention to resume an adequate level of functioning; or
  - b. The member demonstrates significantly impaired educational and/or prevocational/vocational functioning arising from

a mental disorder that requires active intervention to resume an adequate level of functioning.

Level of care for the CMH waiver is specified in 441 IAC 83.122(249A), which provides that “[t]he applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit shall certify the applicant’s level of care annually based on the interRAI standardized assessment tool or other designated standardized assessment tool.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

**The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

**A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The department is using the following assessment tools for evaluate an individual's need for services; for children ages 0 - 3, CM Comprehensive Assessment (or modified PIHH), for ages 4 – 20, interRAI - Child and Youth Mental Health(ChYMH),and for ages 12 - 18, interRAI - Adolescent Supplement (in addition to ChYMH). The interRAI Mental Health Supplement to the Community Health Assessment (CHA-MH) includes an expanded item set on mental health-related diagnoses, symptoms, treatments, and life experiences. The items in this supplement describe the performance and capacity of the person in a variety of domains, with the majority of items serving as specific triggers for care planning. The goal is to use this information to identify individual needs and appropriate interventions.

The domain areas covered in the interRAI CMH include:

Identification Information  
 Intake and Initial History  
 Mental State Indicators  
 Substance Use or Excessive Behavior  
 Harm to Self and Others  
 Behavior  
 Cognition  
 Functional Status  
 Communication and Vision  
 Health Conditions  
 Stress and Trauma  
 Medications  
 Service Utilization and Treatments  
 Nutritional Status  
 Social Relations  
 Employment, Education and Finances  
 Environmental Assessment  
 Diagnostic Information  
 Discharge  
 Community Mental Health supplements

IME Medical Services may request additional information from the case manager, health home coordinator, or community-based case manager to clarify or supplement the information submitted with the assessment. The results of the assessment are used to develop the plan of care. Because the same criteria are used for both institutional care and waiver services, the outcome is reliable, valid, and fully comparable.

- f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

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

The Continued Stay Review (CSR) is completed annually and when the a case manager or health home coordinator becomes aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. The CSR process uses the same assessment tool as is used with the initial level of care determination. It is the responsibility of the case manager or health home coordinator to assure the assessment is initiated as required to complete the CSR. For fee-for-service members, the ISIS system sends out a milestone 60 days prior to the CSR date to remind case managers and health home coordinators of the upcoming annual LOC process. The FFS CSA contractor completes these assessment, and the IME MSU conduct LOC redeterminations.

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

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

MCOs are required to employ the same professionals. Further, MCOs are contractually required to ensure on an ongoing basis that all staff has the appropriate credentials, education, experience and orientation to fulfill the requirements of their position. As applicable based on the scope of services provided under a subcontract, MCOs must ensure all subcontractor staff is trained as well. Staff training shall include, but is not limited to: (i) contract requirements and State and Federal requirements specific to job functions; (ii) training on the MCOs policies and procedures on advance directives; (iii) initial and ongoing training on identifying and handling quality of care concerns; (iv) cultural sensitivity training; (v) training on fraud and abuse and the False Claims Act; (vi) HIPAA training; (vii) clinical protocol training for all clinical staff; (viii) ongoing training, at least quarterly, regarding interpretation and application of utilization management guidelines for all utilization management staff; (ix) assessment processes, person-centered planning and population specific training relevant to the enrolled populations for all care managers; and (x) training and education to understand abuse, neglect, exploitation and prevention including the detection, mandatory reporting, investigation and remediation procedures and requirements. Policies and Procedures Manuals must also be provided to the MCO's entire staff and be incorporated into all training programs for staff responsible for providing services. Finally, MCOs must maintain documentation to confirm staff training, curriculum, schedules and attendance. DHS reserves the right to review training documentation and require the MCO to implement additional staff training.

**g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

**Every three months**

**Every six months**

**Every twelve months**

**Other schedule**

*Specify the other schedule:*

**h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

**The qualifications are different.**

*Specify the qualifications:*

**i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

Reevaluations of fee-for-service members are tracked in the DHS Individualized Services Information System (ISIS). A reminder is sent out to the case manager or health home coordinator for the evaluation 60 days before the reevaluation is due. A CSR report is available through ISIS to track if reevaluations are overdue and is monitored by Medical Services, the Bureau of Long Term Care (BLTC), and IME.

Notification of upcoming annual assessment is also sent to the IME's Core Standardize Assessment contractor. The state's contract manager monthly monitors the timeliness of CSA completion and adherence to the contract's performance measures. Penalties can be applied for failure to adhere to the contract's performance measures. MCO compliance to level of care evaluation requirements are monitored by the MCO account manager and subject matter experts. Penalties can also be applied for failure to adhere to requirements and have been applied to MCOs in these instances.

MCOs are responsible for recording timely completion of level of care reevaluations of members. One hundred percent (100%) of member level of care reevaluations must be completed within twelve (12) months of the previous evaluation. The LOC contractor reports monthly, quarterly and annually on the timeliness of the initial and annual reevaluations completed. DHS reserves the right to audit MCO application of level of care criteria to ensure accuracy and appropriateness.

Should MCO reevaluations not be completed in a timely manner, DHS may require corrective action(s) and implement intermediate sanctions in accordance with 42 CFR 438, Subpart I. The nature of the corrective action(s) will depend upon the nature, severity and duration of the deficiency and repeated nature of the non-compliance. The noncompliance corrective actions may be instituted in any sequence and include, but are not limited to, a written warning, formal corrective action plan, withholding of full or partial capitation payments, suspending auto-assignment, reassigning an MCO's membership and responsibilities, appointing temporary management of the MCO's plan, and contract termination. In the event of non-compliance with reevaluation timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues.

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

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All evaluation and reevaluation level of care documents are faxed to the IME MSU regardless of delivery system (i.e., FFS members and MCO members) and placed in "OnBase." OnBase is the system that stores documents electronically and establishes workflow. In addition, the waiver member's case manager, health home coordinator, or community-based case manager is responsible for service coordination for each member. These providers maintain a working case file for each member and must maintain the records for a period of five years from the date of service. The case file includes all assessments, both initial and ongoing, completed during the time the member was receiving waiver services. MCOs also maintain electronic case management systems that are used to capture and track all evaluations and reevaluations.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States

08/26/2020

methods for discovery and remediation.

**a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

*The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.*

**i. Sub-Assurances:**

**a. Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**LC-a1: IME will measure the number and percent of approved LOC decisions.**

**Numerator: # of completed LOC; Denominator: # of referrals for LOC.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**FFS and MCO members will be pulled from ISIS for this measure. IME MSU completes all initial level of care determinations for both FFS and MCO populations.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; width: 100%; margin-top: 5px;">contracted entity</div>	<b>Annually</b>	<b>Stratified</b> Describe Group:

		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the*

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.**

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**LC-c1: The IME shall determine the number and percent of initial level of care decisions that were accurately determined by applying the approved LOC criterion using standard operating procedures. Numerator: # of of LOC decisions that were accurately determined by applying the correct criteria as defined in the waiver; Denominator: # of reviewed LOC determinations.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**IME MQUIDS and OnBase**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95% +/- 5%</div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; display: inline-block;">Contracted Entity</div>	<b>Annually</b>	<b>Stratified</b> Describe Group:

		IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify:	<input type="text"/>

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Data for completed LOC is collected quarterly through reports generated through ISIS, MQUIDS, and OnBase. This data is monitored for trends from an individual and systems perspective to determine in procedural standards. Monthly a random sample of LOC decisions is selected from each reviewer. IQC activity is completed on the random sample. This level of scrutiny aids in early detection of variance from the stated LOC criteria.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The state's Medical Services Unit performs internal quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred, the unit undertakes additional training for staff.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

---

### B-7: Freedom of Choice

**Freedom of Choice.** As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and*
- ii. given the choice of either institutional or home and community-based services.*

**a. Procedures.** Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**FFS**

DHS is dedicated to serving individuals in the communities of their choice within the resources available and to implementing the United States Supreme Court's mandate in *Olmsted v. L.C.* As such, services are provided in a manner that facilitates maximum community placement and participation for members that require LTSS.

In accordance with 42 CFR 441.301 and the Iowa Administrative Code 441-90.5(1)b and 441-83, service plans must reflect the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan, developed through a "person-centered" planning process, must reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports.

The person-centered process is holistic in addressing the full array of medical and non-medical services and supports to ensure the maximum degree of integration and the best possible health outcomes and member satisfaction. Moreover, members are given the necessary information and support to ensure their direction of the process to the maximum extent possible, and to empower them to make informed choices and decisions regarding the services and supports received.

During enrollment of fee-for-service members, ISIS requires that case managers and health home coordinators attest to having offered a choice between HCBS or institutional services. Choice is verified by : (1) marking the waiver box on the application; (2) sending a written request asking for waiver services; or (3) verbally confirming the member's choice with the income maintenance worker and the case manger or health home coordinator documents the conversation.

Further, there are waiver informational brochures available to share with members and their parents/guardians. Brochures are available at each of the DHS county offices. Information is also available on the IME and MCO websites. The brochures include information on eligibility, service descriptions, and the application process. Once a member begins the enrollment process and has a case manager, health home coordinator, or community-based case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a member's plan of care.

**MCO**

MCO community case managers are required ensure that members are offered choice according to their respective MCO processes and forms, which are reviewed and approved by DHS.

The IME's contractor for HCBS Oversight conducts monthly ride-alongs for MCO service plan coordination and evaluates compliance with service planning requirements, including choice between institutional and HCBS services. Feedback is provided to the MCO account managers, who then follow up on any necessary corrective actions.

In addition, the IME Medical Services Unit (MSU) reviews the person centered service plan to determine if provider choice (including CCO) is offered.

The HCBS Unit, during the IPES member telephone surveys, asks members if they are offered choice of providers. The HCBS regional specialists (part of the HCBS QA Unit) as part of the IDT/CBCM Ride Along activity, identifies if provider choice is offered during the IDT meetings.

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Freedom of Choice forms for fee-for-service members is documented in member service plans and in ISIS.

MCOs are responsible for maintaining records that fully disclose the extent of services provided to members for a minimum of seven years, and must furnish such information to duly authorized and identified agents or representatives of the state and federal governments.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the state uses to provide meaningful access

08/26/2020

to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Iowa DHS adopts the policy as set forth in Title VI of the Civil Rights Act prohibiting national origin discrimination as it affects people with limited English proficiency. DHS shall provide for communication with people with limited English proficiency, including current and prospective patients or clients, family members and members to ensure them an equal opportunity to benefit from services. DHS has developed policies and procedures to ensure meaningful access for people with limited English proficiency. This includes procedures to:

- Identify the points of contact where language assistance is needed.
- Identify translation and interpretation resources, including their location and their availability.
- Arrange to have these resources available in timely manner.
- Determine the written materials and vital documents to be translated, based on the populations with limited English proficiency and ensure their transition.
- Determine effective means for notifying people with limited English proficiency of available translation services available at no cost.
- Train department staff on limited English proficiency requirements and ensure their ability to carry them out.
- Monitor the application of these policies on at least an annual basis to ensure ongoing meaningful access to services.

All applications and informational handouts are printed in Spanish. In addition, the contract with IME Member Services requires that a bilingual staff person be available to answer all telephone calls, emails and written inquiries. They also work with interpreters if another spoken language is needed. All local DHS offices have access to a translator if a bilingual staff person is not available. DHS includes this policy as part of their Policy on Nondiscrimination that can be found in the DHS Title I General Departmental Procedures in the Department Employee Manual.

Locally, each county DHS office utilizes the resources that are available to them. For example, in larger metropolitan areas, local offices have staff that is fluent in Spanish, Bosnian, and Southeastern Asian languages. Some offices utilize translators from DHS Refugee Services. Other areas of the state have high Russian populations and access the translators in the area. All county offices have access to the Language Line service where they may place a telephone call and request a translator when one is not available at the local office. Medicaid members may call the IME Member Services unit with any questions relating to Medicaid, including waiver services. Member Services has translation capabilities similar to the local DHS offices and uses the Language Line to address any language when Member Services does not have an interpreter on staff.

MCOs must conform to DHS policies regarding meaningful access to the waiver by limited English proficient persons, and to deliver culturally competent services in accordance with 42 CFR 438.206.

- MCOs must provide language services at no cost to limited English proficiency members, and all written materials shall be provided in English and Spanish, as well as any additional prevalent languages identified by the State or through an analysis of member enrollment (i.e., any language spoken by at least five percent (5%) of the general population in the MCO's service area).
- MCOs must provide oral interpretation services free of charge to each member (this applies to all non-English languages, and is not limited to prevalent languages), and MCOs must notify all members that oral interpretation and translated written information is available and how to access those services. Written materials must include taglines in prevalent languages regarding how to access materials in alternative languages.
- MCOs must ensure that service plans reflect cultural considerations of the member and that service plan development is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b).
- MCOs must operate member services helplines that are available to all callers, and an automated telephone menu options must be made available in English and Spanish.
- MCOs must maintain member websites and mobile applications available in English and Spanish that are accessible and functional via cell phone.

All MCO developed member communications, including substantive changes to previously approved communications, must be approved by DHS prior to use/distribution.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

**a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Family and Community Support service		
Statutory Service	Respite		
Other Service	Environmental modifications and adaptive devices,		
Other Service	In-home family therapy		

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Habilitation

**Alternate Service Title (if any):**

Family and Community Support service

**HCBS Taxonomy:**

**Category 1:**

10 Other Mental Health and Behavioral Services

**Sub-Category 1:**

10040 behavior support

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Services provided through Family and Community (F&C) Supports Service build upon the therapies provided by mental health professionals, including In Home Family Therapy under this waiver. F&C services are done in the home with the family or in the community with the child; practicing and implementing those coping strategies identified by mental health therapists. Whereas In Home Family Therapy is a skilled therapeutic service, F&C is the practical application of the skills and interventions that will allow the family and child to function more appropriately. An example of F&C: the provider teaches the child appropriate social behavior by taking the child to a fast food restaurant. The child practices not acting out, eating with manners, and thanking the food service workers. Another example: The mental health professional has indicated that the child should experiment with a variety of physical activities that could be used to de-escalate anxiety. The F&C provider takes the child running, walking, or a driving range to find a good activity for the child; and then works with the child to initiate the activity when anxiety is triggered.

Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength. The emphasis in service shall focus on the member and the development of needed skills and improving behaviors that are impacting the family dynamics. Services may be provided in the family home or in the community.

Family and community support services shall be provided under the recommendation and direction of a mental health professional who is part of the member's interdisciplinary team pursuant to 441-83.127(249A). Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

- (1) Developing and maintaining a crisis support network for the member and for the member's family.
- (2) Modeling and coaching effective coping strategies for the member's family members.
- (3) Building resilience to the stigma of serious emotional disturbance for the member and the family.
- (4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.
- (5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 44124.1(225C) for life situations with the member's family and in the community.
- (6) Developing medication management skills.
- (7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.
- (8) Developing positive socialization and citizenship skills.

Therapeutic resources may include books, training materials, and visual or audio media. The therapeutic resources shall be identified as a need of the member in the member's authorized service plan and shall be used as part of the implementation and delivery of the family and community support service.

- (1) The interdisciplinary team must identify the transportation or therapeutic resource as a support need.
- (2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.
- (3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.
- (4) The member's IHH Care Coordinator shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.
- (5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

The following components are specifically excluded from family and community support services:

- (1) Vocational services.
- (2) Prevocational services.
- (3) Supported employment services.
- (4) Room and board.
- (5) Academic services.
- (6) General supervision and consumer care.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

A unit of service will be 15 minutes.

Family and community support services may include an amount not to exceed \$1500 per member per year for transportation within the community and the purchase of therapeutic resources. An amount of funds, up to \$1,500.00 annually, may be approved for use for transportation or identified therapeutic resources for the member. Transportation shall only be provided for the implementation of the approved family and community support services. Once approved in the member's service plan the amount of funds authorized for the needed transportation and therapeutic resources is incorporated into the enrolled provider's rate for service.

Members enrolled in the CMH waiver have access to Iowa's Medicaid Exception to Policy option. ETPs can be requested to Iowa Administrative Code (IAC) rules, but cannot be requested for Federal requirements or state law. Members needing additional transportation or therapeutic resources in order to ensure health, safety, or other issues can request ETPs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding ETP requests are approved by the Department of Human Services director.

The limitation is included in the IAC Chapter 78; citation is 78.52(3) Family and community support services. In addition, the limit is referenced in the CMH Waiver Information Packet that is available on the Department's Medicaid Website. FFS Case Managers, Integrated Health Home Care Coordinators, and MCO Community Based Case Managers are responsible to educate members regarding all service limitations during the service planning process.

The family and community support service is cost settled at the end of each fiscal year through a retrospectively limited prospective rate setting methodology identified in this application.

Services provided under IDEA or the Rehabilitation Act of 1973 are not available.

**Service Delivery Method** *(check each that applies):*

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by** *(check each that applies):*

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Mental Health Centers
Agency	Behavioral Health Intervention providers

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**  
**Service Name: Family and Community Support service**

**Provider Category:**

Agency

**Provider Type:**

Community Mental Health Centers

**Provider Qualifications**

**License (specify):**

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate (specify):**

Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441Chapter 24.

**Other Standard (specify):**

Behavioral Health Intervention Services employees must:

- 1)Have a Bachelor's degree in a social science field +
  - a)1 year experience OR
  - b)20 hours CMH training

OR

- 2)Have a Bachelor's degree in a social science field +
  - a)2 years experience OR
  - b)30 hours CMH training

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training (see above).
- (3) Subject to background checks prior to direct service delivery.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Family and Community Support service**

**Provider Category:**

Agency

**Provider Type:**

Behavioral Health Intervention providers

**Provider Qualifications**

**License (specify):**

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate (specify):**

**Other Standard** (*specify*):

Behavioral Health Intervention services providers qualified under 44177.12(249A): A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is enrolled in the Iowa Plan for Behavioral Health pursuant to 441—Chapter 88, Division IV.

The following enrollment criteria is applied to organizations enrolling as Behavioral Health Intervention providers under 441-77.12:

1. Mental Health Provider or Community Mental Health Provider as defined in IAC 441-24.

“Mental health service provider” means an organization whose services are established to specifically address mental health services to individuals or the administration of facilities in which these services are provided.

“Community mental health provider” means an organization providing mental health services that is established pursuant to Iowa Code chapters 225C and 230A.

2. A residential group care setting licensed under IAC441-114: a facility which provides care for children who are considered unable to live in a family situation due to social, emotional or physical disabilities but

are capable of interacting in a community environment with a minimum amount of supervision. Please note: children in foster care are not eligible for the CMH waiver and would not be receiving CMH funded services while in foster care.

3. A Psychiatric Medical Institution for Children. Please note: children in a PMIC are not eligible for the CMH waiver and would not be receiving CMH funded services while in a PMIC.

4. National accredited by COA, the Joint commission or CARF under the accreditation standard that apply to mental health rehabilitative services.

Staff within the enrolled organization must meet the following credentialing standards:

1. Bachelor’s degree in social sciences field plus additional experience or training or
2. Bachelor’s degree in non-social science field plus more additional experience or training

Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 135C.33(5)“a”(1) before employment of a staff member who will provide direct care.

Behavioral Health Intervention Services employees must:

- 1)Have a Bachelor's degree in a social science field +
  - a)1 year experience OR
  - b)20 hours CMH training

OR

- 2)Have a Bachelor's degree in a social science field +
  - a)2 years experience OR
  - b)30 hours CMH training

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training (see above).
- (3) Subject to background checks prior to direct service delivery.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

Respite

**HCBS Taxonomy:**

**Category 1:**

09 Caregiver Support

**Sub-Category 1:**

09011 respite, out-of-home

**Category 2:**

09 Caregiver Support

**Sub-Category 2:**

09012 respite, in-home

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

Respite shall be provided in an environment (member's home, provider's home, camp, etc.) as approved by the interdisciplinary team.

FFP may be claimed for respite provided in a hospital or RCF/ID.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

1. Respite care shall not be provided to members during the hours in which the usual caregiver is employed, except when the member is attending a camp.
2. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision.
3. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite and defined in rule 441- Chapter 83.
4. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.
5. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.
6. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.
6. Effective 7/1/13, a unit of service is 15 minutes.

Services provided under IDEA or the Rehabilitation Act of 1973 are not available.

**Service Delivery Method** *(check each that applies):*

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** *(check each that applies):*

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	HCBS respite provider
Agency	Assisted Living programs
Agency	Child Care Centers and Child Development Homes
Agency	Nursing Facilities, ICF/ID, and Hospitals
Agency	Home Care Agencies
Agency	Foster Care
Agency	Adult Day Care
Agency	Camps
Agency	Home Health Agencies
Agency	Residential Care Facilities for Persons with Intellectual Disability

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

HCBS respite provider

**Provider Qualifications**

**License** *(specify):*

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate** (*specify*):

Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.

**Other Standard** (*specify*):

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

Qualified Training includes:

- (1) Within one month of employment, staff members must receive the following training:
  1. Orientation regarding the agency's mission, policies, and procedures; and
  2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1)"c."
- (2) Within four months of employment, staff members must receive training regarding the following:
  1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
  2. Confidentiality;
  3. Provision of medication according to agency policy and procedure;
  4. Identification and reporting of child abuse;
  5. Incident reporting;
  6. Documentation of service provision;
  7. Appropriate behavioral interventions; and
  8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Assisted Living programs

**Provider Qualifications**

**License** (*specify*):

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate** (*specify*):

Assisted living programs certified in good standing by the Iowa department of inspections and appeals.

**Other Standard** (*specify*):

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

Qualified Training includes:

- (1) Within one month of employment, staff members must receive the following training:
  1. Orientation regarding the agency's mission, policies, and procedures; and
  2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1)"c."
- (2) Within four months of employment, staff members must receive training regarding the following:
  1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
  2. Confidentiality;
  3. Provision of medication according to agency policy and procedure;
  4. Identification and reporting of child abuse;
  5. Incident reporting;
  6. Documentation of service provision;
  7. Appropriate behavioral interventions; and
  8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Child Care Centers and Child Development Homes

**Provider Qualifications**

**License** (*specify*):

Child care centers licensed in good standing by the department according to IAC 441Chapter 109 and child development homes registered according to IAC 441Chapter 110.

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate** (*specify*):

**Other Standard** (*specify*):

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

Qualified by training must include the following:

The provider shall receive two hours of Iowa's training for mandatory reporting of child abuse:

- (1) During the first three months of registration as a child development home; and
- (2) Every five years thereafter.

b. The provider shall obtain first-aid training within the first three months of registration as a child development home.

(1) First-aid training shall be provided by a nationally recognized training organization, such as the American Red Cross, the American Heart Association, the National Safety Council, or Emergency Medical Planning (Medic First Aid) or by an equivalent trainer using curriculum approved by the department.

(2) First-aid training shall include certification in infant and child first aid that includes management of a blocked airway and mouth-to-mouth resuscitation.

(3) The provider shall maintain a valid certificate indicating the date of first-aid training and the expiration date.

c. During the first year of registration, the provider shall receive a minimum of 12 hours of training from one or more of the following content areas. The provider shall receive at least 6 of these hours in a group setting as defined in subrule 110.5(12), and 2 of the hours must be from the content area in subparagraph 110.5(11)“c”(1). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

- (1) Planning a safe, healthy learning environment (includes nutrition).
- (2) Steps to advance children's physical and intellectual development.
- (3) Positive ways to support children's social and emotional development (includes guidance and discipline).
- (4) Strategies to establish productive relationships with families (includes communication skills and cross-cultural competence).
- (5) Strategies to manage an effective program operation (includes business practices).
- (6) Maintaining a commitment to professionalism.
- (7) Observing and recording children's behavior.
- (8) Principles of child growth and development.

d. During the second year of registration and each succeeding year, the provider shall receive a minimum of 12 hours of training from one or more of the content areas as defined in paragraph “c.” The provider shall receive at least 6 of these hours in a group setting as defined in subrule 110.5(12). The provider may receive the remaining hours in self-study as defined in subrule 110.5(13). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

e. A provider who submits documentation from a child care resource and referral agency that the provider has completed the Iowa Program for Infant/Toddler Care (IA PITC), ChildNet, or Beyond Business Basics training series may use those hours to fulfill a maximum of two years' training requirements, not including first-aid and mandatory reporter training.

and

Staff training. The agency shall meet the following training requirements as a condition of providing respite care under the children's mental health waiver:

- (1) Within one month of employment, staff members must receive the following training:
  1. Orientation regarding the agency's mission, policies, and procedures; and
  2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1)“c.”
- (2) Within four months of employment, staff members must receive training regarding the following:
  1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
  2. Confidentiality;
  3. Provision of medication according to agency policy and procedure;

- 4. Identification and reporting of child abuse;
  - 5. Incident reporting;
  - 6. Documentation of service provision;
  - 7. Appropriate behavioral interventions; and
  - 8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children’s mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children’s mental health issues.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Nursing Facilities, ICF/ID, and Hospitals

**Provider Qualifications**

**License (specify):**

Nursing facilities, intermediate care facilities for the intellectually disabled, and hospitals enrolled as providers in the Iowa Medicaid program.

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers’ compensation insurance.

**Certificate (specify):**

**Other Standard (specify):**

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

Qualified Training includes:

- (1) Within one month of employment, staff members must receive the following training:
  - 1. Orientation regarding the agency’s mission, policies, and procedures; and
  - 2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children’s mental health waiver in 77.46(1)“c.”
- (2) Within four months of employment, staff members must receive training regarding the following:
  - 1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
  - 2. Confidentiality;
  - 3. Provision of medication according to agency policy and procedure;
  - 4. Identification and reporting of child abuse;
  - 5. Incident reporting;
  - 6. Documentation of service provision;
  - 7. Appropriate behavioral interventions; and
  - 8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children’s mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children’s mental health issues.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agencies

**Provider Qualifications**

**License (specify):**

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers’ compensation insurance.

**Certificate (specify):**

--

**Other Standard** (*specify*):

Home care agencies that meet the requirements set forth in department of public health rule IAC 64180.7(135): Professional staff as providers of home care aide services. An individual who is in the process of receiving or who has completed the training required for LPN or RN licensure or who possesses an associate's degree or higher in social work, sociology, home economics or other health or human services field may be assigned to provide home care aide services if the following conditions are met:

- a. Services or tasks assigned are appropriate to the individual's prior training.
- b. Orientation to home care is conducted. Orientation includes adaptation of the individual's knowledge and skills from prior education to the home setting and to the role of the home care aide.

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

Qualified Training includes:

- (1) Within one month of employment, staff members must receive the following training:
  1. Orientation regarding the agency's mission, policies, and procedures; and
  2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1)"c."
- (2) Within four months of employment, staff members must receive training regarding the following:
  1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
  2. Confidentiality;
  3. Provision of medication according to agency policy and procedure;
  4. Identification and reporting of child abuse;
  5. Incident reporting;
  6. Documentation of service provision;
  7. Appropriate behavioral interventions; and
  8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
---

**Frequency of Verification:**

Every Four years
------------------

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

---

**Service Type: Statutory Service**

**Service Name: Respite**

---

**Provider Category:**

Agency

**Provider Type:**

Foster Care

**Provider Qualifications**

**License** (*specify*):

Group living foster care facilities for children licensed in good standing by the department according to Iowa Administrative Code (IAC) 441 Chapters 112 and 114 to 116.

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate** (*specify*):

**Other Standard** (*specify*):

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

Qualified Training includes:

- (1) Within one month of employment, staff members must receive the following training:
  1. Orientation regarding the agency's mission, policies, and procedures; and
  2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1)"c."
- (2) Within four months of employment, staff members must receive training regarding the following:
  1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
  2. Confidentiality;
  3. Provision of medication according to agency policy and procedure;
  4. Identification and reporting of child abuse;
  5. Incident reporting;
  6. Documentation of service provision;
  7. Appropriate behavioral interventions; and
  8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Adult Day Care

**Provider Qualifications**

**License** (*specify*):

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate** (*specify*):

Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department on aging at IAC 321Chapter 24.

**Other Standard** (*specify*):

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

Qualified Training includes:

- (1) Within one month of employment, staff members must receive the following training:
  - 1. Orientation regarding the agency’s mission, policies, and procedures; and
  - 2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children’s mental health waiver in 77.46(1)“c.”
- (2) Within four months of employment, staff members must receive training regarding the following:
  - 1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
  - 2. Confidentiality;
  - 3. Provision of medication according to agency policy and procedure;
  - 4. Identification and reporting of child abuse;
  - 5. Incident reporting;
  - 6. Documentation of service provision;
  - 7. Appropriate behavioral interventions; and
  - 8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children’s mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children’s mental health issues.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Camps

**Provider Qualifications**

**License (specify):**

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers’ compensation insurance.

**Certificate** (*specify*):

Camps certified in good standing by the American Camping Association.

**Other Standard** (*specify*):

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

Qualified Training includes:

- (1) Within one month of employment, staff members must receive the following training:
  1. Orientation regarding the agency's mission, policies, and procedures; and
  2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1)"c."
- (2) Within four months of employment, staff members must receive training regarding the following:
  1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
  2. Confidentiality;
  3. Provision of medication according to agency policy and procedure;
  4. Identification and reporting of child abuse;
  5. Incident reporting;
  6. Documentation of service provision;
  7. Appropriate behavioral interventions; and
  8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agencies

**Provider Qualifications**

**License** (*specify*):

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate** (specify):

Home health agencies that are certified in good standing to participate in the Medicare program.

**Other Standard** (specify):

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

Qualified Training includes:

- (1) Within one month of employment, staff members must receive the following training:
  1. Orientation regarding the agency's mission, policies, and procedures; and
  2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1)"c."
- (2) Within four months of employment, staff members must receive training regarding the following:
  1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
  2. Confidentiality;
  3. Provision of medication according to agency policy and procedure;
  4. Identification and reporting of child abuse;
  5. Incident reporting;
  6. Documentation of service provision;
  7. Appropriate behavioral interventions; and
  8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

## Residential Care Facilities for Persons with Intellectual Disability

**Provider Qualifications****License** (*specify*):

Residential care facilities for persons with Intellectual Disability licensed in good standing by the department of inspections and appeals.

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate** (*specify*):
**Other Standard** (*specify*):

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

Qualified Training includes:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and
2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1)"c."

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
2. Confidentiality;
3. Provision of medication according to agency policy and procedure;
4. Identification and reporting of child abuse;
5. Incident reporting;
6. Documentation of service provision;
7. Appropriate behavioral interventions; and
8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Environmental modifications and adaptive devices,

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14020 home and/or vehicle accessibility adaptations

**Category 2:**

14 Equipment, Technology, and Modifications

**Sub-Category 2:**

14031 equipment and technology

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Environmental modifications and adaptive devices includes items installed or used within the member's home that address specific, documented health, mental health, or safety concerns. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the member.

The services under the Children’s Mental Health Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.”

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services. The CMH waiver only provides services to members that live within the family home.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

1. A unit of service is one modification or device.
2. For each unit of service provided, the case manager, IHH Care Coordinator or CBCM shall maintain in the member’s case file a signed statement from the mental health professional on the member’s interdisciplinary team that the service has a direct relationship to the member’s diagnosis of serious emotional disturbance.
3. Environmental modifications and adaptive devices are limited by the maximum contained in the Iowa Administrative Code Chapter 79. The department has a process for Exceptions to Policy that allow for a member to request funding that exceeds the annual limit for this service. The request for an ETP is evaluated based upon the member’s situation and the availability of other more cost effective solutions to the need.
4. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17). This rule bases payment under the waiver to the same pricing methodologies used by state plan durable medical equipment.

There is an annual limit to the total amount of funds available for Environmental Modifications and Adaptive Devices which are subject to change on a yearly basis based upon action of the Iowa Legislature. This annual amount is available through the Iowa Administrative Code Chapter 79.

Services provided under IDEA or the Rehabilitation Act of 1973 are not available.

**Service Delivery Method** *(check each that applies):*

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** *(check each that applies):*

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Family and Community Support provider
Agency	community business
Agency	HCBS Supported Community Living provider
Agency	retail/ wholesale business
Agency	Home and Vehicle Modification provider

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Environmental modifications and adaptive devices,**

**Provider Category:**

Agency

**Provider Type:**

Family and Community Support provider

**Provider Qualifications**

**License** *(specify):*

Behavioral Health Intervention providers enrolled with the Iowa Plan for Behavioral Health

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate** (specify):

**Other Standard** (specify):

A provider enrolled under the HCBS CMH waiver as a family and community support services provider. Often there are no enrolled providers available in an area due to being rural and providers not willing to go through the enrollment process for a one time modification. The "Other Standard" criteria for CMH waiver providers allows an enrolled HCBS waiver provider to be the provider in CMH waiver and subcontract out the modifications to local qualified providers. The CMH waiver provider acts in an administrative function for billing for the modification. An OHCDs arrangement must be in place when utilizing subcontractors.

Behavioral Health Intervention services providers qualified under 441—77.12(249A).

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training
  - Behavioral Health Intervention Services employees must:
    - 1) Have a Bachelor's degree in a social science field +
      - a) 1 year experience OR
      - b) 20 hours CMH training
    - OR
    - 2) Have a Bachelor's degree in a social science field +
      - a) 2 years experience OR
      - b) 30 hours CMH training
- (3) Subject to background checks prior to direct service delivery.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Environmental modifications and adaptive devices,**

**Provider Category:**

Agency

**Provider Type:**

community business

**Provider Qualifications**

**License (specify):**

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate (specify):**

**Other Standard (specify):**

Providers must be:  
(1) At least 18 years of age.  
(2) Subject to background checks prior to direct service delivery.

An OHCDs arrangement must be in place when utilizing subcontractors.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Environmental modifications and adaptive devices,**

**Provider Category:**

Agency

**Provider Type:**

HCBS Supported Community Living provider

**Provider Qualifications**

**License (specify):**

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate (specify):**

**Other Standard (specify):**

A provider enrolled under the HCBS intellectual disabilities or brain injury waiver as a supported community living provider. Often there are no enrolled providers available in an area due to being rural and providers not willing to go through the enrollment process for a one time modification. The "Other Standard" criteria for the CMH waiver allows an enrolled HCBS waiver provider to be the provider in CMH waiver and subcontract out the modifications to local qualified providers. The CMH waiver provider acts in an administrative function for billing for the modification. An OHCDs arrangement must be in place when utilizing subcontractors.

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

This training includes at a minimum:

- (1) Consumer rights.
- (2) Confidentiality.
- (3) Provision of consumer medication.
- (4) Identification and reporting of child and dependent adult abuse.
- (5) Individual consumer support needs.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Environmental modifications and adaptive devices,**

**Provider Category:**

Agency

**Provider Type:**

retail/ wholesale business

**Provider Qualifications**

**License (specify):**

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate (specify):**

**Other Standard (specify):**

A retail or wholesale business that otherwise participates as a provider in the Medicaid program. Often there are no enrolled providers available in an area due to being rural and providers not willing to go through the enrollment process for a one time modification. The "Other Standard" criteria for CMH waiver providers allows an enrolled HCBS waiver provider to be the provider in CMH waiver and subcontract out the modifications to local qualified providers. The CMH waiver provider acts in an administrative function for billing for the modification. The retail/wholesale business allows for the purchase of adaptive devices that do not require a home modification. An OHCDs arrangement must be in place when utilizing subcontractors.

Providers must be:

- (1) At least 18 years of age.
- (2) Subject to background checks prior to direct service delivery.

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

##### Frequency of Verification:

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type:** Other Service

**Service Name:** Environmental modifications and adaptive devices,

#### Provider Category:

Agency

#### Provider Type:

Home and Vehicle Modification provider

#### Provider Qualifications

**License** (*specify*):

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate** (*specify*):

**Other Standard** (*specify*):

A home and vehicle modification provider enrolled under another HCBS Medicaid waiver. Often there are no enrolled providers available in an area due to being rural and providers not willing to go through the enrollment process for a one time modification. The "Other Standard" criteria for CMH waiver providers allows an enrolled HCBS waiver provider to be the provider in CMH waiver and subcontract out the modifications to local qualified providers. The CMH waiver provider acts in an administrative function for billing for the modification.

An OHCDs arrangement must be in place when utilizing subcontractors.

Providers must be:

- (1) At least 18 years of age.
- (2) Subject to background checks prior to direct service delivery.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

In-home family therapy

**HCBS Taxonomy:**

**Category 1:**

10 Other Mental Health and Behavioral Services

**Sub-Category 1:**

10060 counseling

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment. The goal of in-home family therapy is to maintain a cohesive family unit.

In-home family therapy uses clinically trained therapists to develop the coping strategies. The in-home family therapy service is different from the family and community supports service in that the family and community supports implements and teaches the skills to the member and the family, while in-home therapy does not. The in-home family service must be provided within the family home.

Contrasting Family and Community Supports (F&C) services and In Home Family Therapy through the CMH waiver: Services provided through Family and Community (F&C) Supports Service build upon the therapies provided by mental health professionals, including In Home Family Therapy under this waiver. F&C services are done in the home with the family or in the community with the child; practicing and implementing those coping strategies identified by mental health therapists. Whereas In Home Family Therapy is a skilled therapeutic service, F&C is the practical application of the skills and interventions that will allow the family and child to function more appropriately. An example of F&C: the provider teaches the child appropriate social behavior by taking the child to a fast food restaurant. The child practices not acting out, eating with manners, and thanking the food service workers. Another example: The mental health professional has indicated that the child should experiment with a variety of physical activities that could be used to de-escalate anxiety. The F&C provider takes the child running, walking, or a driving range to find a good activity for the child; and then works with the child to initiate the activity when anxiety is triggered.

The services under the Children’s Mental Health Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.”

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

In-home family therapy is exclusive of, and cannot serve as, a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Medicaid or other funding sources and will not be duplicative of any waiver services.

A unit of in-home family therapy service is 15 minutes.

Services provided under IDEA or the Rehabilitation Act of 1973 are not available.

This service shall not be duplicative of and does not take the place of services provided under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

**Service Delivery Method** (check each that applies):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (check each that applies):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Mental health professionals
Agency	Community mental health centers

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: In-home family therapy**

**Provider Category:**

Individual

**Provider Type:**

Mental health professionals

**Provider Qualifications**

**License** (*specify*):

Mental health professionals licensed pursuant to 645Chapter 31, 240, or 280 or possessing an equivalent license in another state.

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate** (*specify*):

**Other Standard** (*specify*):

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

Training shall include:

- (1) Within one month of employment, staff members must receive the following training:
  1. Orientation regarding the agency’s mission, policies, and procedures; and
  2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46 (1)“c” for the children’s mental health waiver.
- (2) Within four months of employment, staff members must receive training regarding the following:  
 Page 59 of 64  
[http://search.legis.state.ia.us/nxt/gateway.dll/ar/iac/4410\\_\\_\\_human%20services%20departm...](http://search.legis.state.ia.us/nxt/gateway.dll/ar/iac/4410___human%20services%20departm...) 8/8/2012
  1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;
  2. Confidentiality;
  3. Provision of medication according to agency policy and procedure;
  4. Identification and reporting of child abuse;
  5. Incident reporting;
  6. Documentation of service provision;
  7. Appropriate behavioral interventions; and
  8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children’s mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children’s mental health issues.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Enrollment Unit

**Frequency of Verification:**

every four years

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: In-home family therapy**

**Provider Category:**

Agency

**Provider Type:**

Community mental health centers

**Provider Qualifications**

**License (specify):**

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers’ compensation insurance.

**Certificate** (*specify*):

Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441Chapter 24.

**Other Standard** (*specify*):

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

Training shall include:

- (1) Within one month of employment, staff members must receive the following training:
  1. Orientation regarding the agency's mission, policies, and procedures; and
  2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46 (1)"c" for the children's mental health waiver.
- (2) Within four months of employment, staff members must receive training regarding the following:

Page 59 of 64

[http://search.legis.state.ia.us/nxt/gateway.dll/ar/iac/4410\\_\\_\\_human%20services%20departm...](http://search.legis.state.ia.us/nxt/gateway.dll/ar/iac/4410___human%20services%20departm...) 8/8/2012

1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;
2. Confidentiality;
3. Provision of medication according to agency policy and procedure;
4. Identification and reporting of child abuse;
5. Incident reporting;
6. Documentation of service provision;
7. Appropriate behavioral interventions; and
8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Iowa Department of Human Services, the Iowa Medicaid Enterprise, Provider Enrollment Unit

**Frequency of Verification:**

Every four years

**Appendix C: Participant Services****C-1: Summary of Services Covered (2 of 2)**

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

**Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

**As a waiver service defined in Appendix C-3. Do not complete item C-1-c.**

**As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.**

**As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.**

**As an administrative activity. Complete item C-1-c.**

**As a primary care case management system service under a concurrent managed care authority. Complete item C-1-c.**

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

FFS:

Targeted case managers or integrated health home coordinators provide case management services to those fee-for-service members enrolled in the State's §1915(c) Children's Mental Health Waiver. Services are reimbursed through an administrative function of DHS.

All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned.

MCO community-based case managers provide case management services to all members receiving HCBS. MCOs ensure ease of access and responsiveness for each member to their community-based case manager during regular business hours and, at a minimum, the community-based case manager contacts members at least monthly, either in person or by phone, with an interval of at least fourteen calendar days between contacts.

Targeted case management (TCM) may be provided to CMH waiver members by four different provider types. The individual counties within the state establish contracts for providing targeted case management within the county. The TCM provider options include TCM provided by: (1) Department of Human Services; (2) County Case Management; (3) private case management entities; or (4) providers that are accredited for case management by national accrediting bodies (e.g., CARF). All TCM units are required to be accredited by the state of Iowa Mental Health and Disabilities Services for 441 Iowa Administrative Code Chapter 24 case management services. All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned. MCOs are contractually required to ensure the delivery of services in a conflict free manner consistent with

Balancing Incentive Program requirements. DHS approves and monitors all MCO policies and procedures to ensure compliance.

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

**No. Criminal history and/or background investigations are not required.**

**Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):



Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a member:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

1. For purposes of this section and section 249A.30 unless the context otherwise requires:
  - a. "Consumer" means an individual approved by the department to receive services under a waiver.
  - b. "Provider" means an agency certified by the department to provide services under a waiver.
  - c. "Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2. If a person is being considered by a provider for employment involving direct responsibility for a consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department [(Department of Human Services)] shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the criminal background checks. The provider agency is responsible for completing the required waiver to perform the criminal background check and submitting to the Department of Public Safety who conducts the check. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of criminal background checks are available to the Department upon request. The IME will assure that criminal background checks have been completed through quality improvement activities on a random sampling of providers, focused onsite reviews and during the full on-site reviews conducted every 5 years.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. Screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. DHS also completes any evaluation needed for screenings returned with records or charges. Background checks only include Iowa unless the applicant is a resident of another state providing services in Iowa.

The annual provider self-assessment requires providers to attest to the completion of Dependent adult and child abuse checks, criminal history background checks and Department of Human Services (DHS) evaluation as applicable, documentation of the follow through on any restrictions stated in the DHS evaluation, and completion of the Office of Inspector General (OIG) excluded individual search. The provider is required to attest that there is evidence of this in all employee files. During the onsite HCBS review process a random sample of personnel files are pulled and it is verified that evidence is in place supporting the agency completed the required information for all of their direct care staff.

MCOs are contractually required to assure that all persons, whether they are employees, agents, subcontractors, or anyone acting for or on behalf of the MCO, are properly licensed, certified, or accredited as required under applicable state law and the Iowa Administrative Code. The Contractor shall provide standards for service providers who are not otherwise licensed, certified, or accredited under state law or the Iowa Administrative Code.

**b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

**No. The state does not conduct abuse registry screening.**

**Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a member:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

1. For purposes of this section and section 249A.30 unless the context otherwise requires:
  - a. "Consumer" means an individual approved by the department to receive services under a waiver.
  - b. "Provider" means an agency certified by the department to provide services under a waiver.
  - c. "Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2. If a person is being considered by a provider for employment involving direct responsibility for a consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

The Iowa Department of Human Services maintains the Central Abuse Registry. All child and dependent adult abuse checks are conducted by the DHS unit responsible for the intake, investigation, and finding of child and dependent adult abuse. The provider agency is responsible for completing the required abuse screening form and submitting it to DHS to conduct the screening. Providers are required to complete the child and dependent adult abuse background checks of all staff that provides direct services to waiver members prior to employment. Providers are required to have written policies and procedures for the screening of personnel for child and dependent adult abuse checks prior to employment. As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the child and dependent adult abuse checks. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of child and dependent adult abuse checks are available to the Department upon request. The Department will assure that the child and dependent adult abuse checks have been completed through the Department's quality improvement activities of random sampling of providers, focused onsite reviews, initial certification and periodic reviews and during the full on-site reviews conducted every 5 years.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. Screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. DHS also completes any evaluation needed for screenings returned with records or charges. MCOs are also required to ensure that all required screening is conducted for providers who are not employees of a provider agency or licensed/accredited by a board that conducts background checks (i.e., non-agency affiliated self-direction service providers). DHS retains final authority

to determine if an employee may work in a particular program.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:***

**No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

**Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

**No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

**Self-directed**

**Agency-operated**

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

**The state does not make payment to relatives/legal guardians for furnishing waiver services.**

**The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

A member's legal guardian may not provide services to a member on the CMH waiver, but relatives may be paid providers of service. The relative would be an employee of a provider agency and the provider has the responsibility to assure the relative has the skills needed to provide the services to the member. In many situations, the Medicaid member requests the relative to provide services, as they may know the member and their needs best. In other circumstances, there are no other qualified providers available when the service is needed or a lack of staff in the area to provide the service. The rate of pay and the care provided by the relative is identified and authorized in the member's plan of care that is authorized and monitored by the member's case manager, IHH Care Coordinator or community-based case manager.

The case manager, IHH Care Coordinator, or community-based case manager is responsible to monitor service plans and to assure that the services authorized in the member's plan are received. In addition, information on paid claims for fee-for-service members is available in ISIS for the case manager and IHH Care Coordinator to review. The MMIS System compares the submitted claim to the services authorized in the plan of care prior to payment. The claim will be paid if the amount billed is lower than what is authorized in the plan.

The state also completes post utilization audits on CMH Waiver providers verifying that services rendered match the service plan and claim process. MCOs are required to adhere to all state policies, procedures and regulations regarding payment to legal guardians, as outlined in this section.

**Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Iowa Medicaid providers will be responsible for providing services to fee-for-service members. The Iowa Medicaid Provider Services Department markets provider enrollment for Iowa Medicaid. Potential providers may access an application on line through the website or by calling the provider services' phone number. The IME Provider Services Unit must respond in writing within five working days once a provider enrollment application is received, and must either accept the enrollment application and approve the provider as a Medicaid provider or request more information. In addition, waiver quality assurance staff and waiver program managers, as well as county and State service workers, case managers, health home coordinators, market to qualified providers to enroll in Medicaid.

MCOs are responsible for oversight of their provider networks. State ensures that LTSS providers are given the opportunity for continued participation in the managed care networks by regularly monitoring the managed care organization provider network and evaluating rationales for not having providers in their networks.

While the number of providers not contracted with all managed care organizations is small, the rationale includes providers not accepting the "floor" rates determined by the State and wanting enhanced rates. The State additionally tracks on provider inquiries and complaints which includes complaints related to network access and credentialing.

## Appendix C: Participant Services

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

**a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

**i. Sub-Assurances:**

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**QP-a1: The IME will measure the number of newly enrolled licensed or certified waiver provider enrollment applications verified against the appropriate licensing or certification entity Numerator = # of newly enrolled waiver providers verified against appropriate licensing or certification entity prior to providing services Denominator = # of newly enrolled licensed or certified waiver providers.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>

<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;">Contracted Entity</div>	<p><b>Annually</b></p>	<p><b>Stratified</b> Describe Group:</p> <div style="border: 1px solid black; width: 100px; height: 30px;"></div>
	<p><b>Continuously and Ongoing</b></p>	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; width: 100px; height: 30px;"></div>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; width: 100px; height: 30px;"></div>	

**Data Aggregation and Analysis:**

<p><b>Responsible Party for data aggregation and analysis</b> (<i>check each that applies</i>):</p>	<p><b>Frequency of data aggregation and analysis</b>(<i>check each that applies</i>):</p>
<p><b>State Medicaid Agency</b></p>	<p><b>Weekly</b></p>
<p><b>Operating Agency</b></p>	<p><b>Monthly</b></p>
<p><b>Sub-State Entity</b></p>	<p><b>Quarterly</b></p>
<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>	<p><b>Annually</b></p>
	<p><b>Continuously and Ongoing</b></p>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>

**Performance Measure:**

**QP-a2** The IME will measure the number of licensed or certified waiver provider re-enrollments verified against the appropriate licensing and/or certification entity.  
**Numerator = # of waiver provider re-enrollments verified against appropriate licensing and or certification entity prior to providing services**  
**Denominator = # of licensed or certified waiver provider re-enrollments.**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated**

If 'Other' is selected, specify:

**re-enrollment information out of ISIS. All MCO HCBS providers must be re-enrolled as verified by the IME Provider Services unit every 5 years**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="contracted entity"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**QP-b3: The IME shall determine the number and percent of non-licensed/noncertified providers that met waiver requirements prior to direct service delivery. Numerator = # of non-licensed/noncertified providers who met waiver requirements prior to service delivery; Denominator = # of non-licensed/noncertified enrolled providers.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider Enrollment records, Individualized Services Information System (ISIS), claims.**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100%</b>

		<b>Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="contracted entity"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):

**c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**QP-c1: The IME will measure the total number and percent of providers, specific by waiver, that meet training requirements as outlined in State regulations. Numerator = # of reviewed HCBS providers which did not have a corrective action plan issued related to training; Denominator = # of HCBS waiver providers that had a certification or periodic quality assurance review.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

**Provider's evidence of staff training and provider training policies. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

Contracted Entity <input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input style="width: 100%;" type="text"/>
	<b>Other</b> Specify: <input style="width: 100%;" type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%;" type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The IME Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment.  
All MCO providers must be enrolled as verified by IME Provider Services.

The Home and Community Based Services (HCBS) quality oversight unit is responsible for reviewing provider records at a 100% level over a three to five year cycle, depending on certification or accreditation. If it is discovered that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated if noncompliance persists.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

If it is discovered by Provider Services Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, the provider is required to correct deficiency prior to enrollment or reenrollment approval. Until the provider make these corrections, they are ineligible to provide services to waiver members. All MCO providers must be enrolled as verified by IME Provider Services, so if the provider is no longer enrolled by the IME then that provider is no longer eligible to enroll with an MCO.

If it is discovered during HCBS Quality Oversight Unit review that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated is noncompliance persists.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and required changes in individual provider policy.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text" value="Contracted Entity and MCOs"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

**Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable -** The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.  
*Furnish the information specified above.*

**Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

**Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*

**Other Type of Limit.** The state employs another type of limit.

*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

Detailed information and timelines for the HCBS Settings project are included in Attachment #2 HCBS Settings. The Iowa Medicaid Enterprise received initial CMS approval for Iowa's statewide HCBS transition plan on August 10, 2016.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

#### State Participant-Centered Service Plan Title:

Individual Service Plan

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

**Registered nurse, licensed to practice in the state**

**Licensed practical or vocational nurse, acting within the scope of practice under state law**

**Licensed physician (M.D. or D.O)**

**Case Manager** (qualifications specified in Appendix C-1/C-3)

**Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

In order for an Agency to meet the requirements of 441 Iowa Administrative Code 24 for case management services, the Agency submits certification papers along with a provider application in order to be enrolled to provide case management. An Agency that is accredited through the Commission on Accreditation of Rehabilitation Facilities (CARF) for Case Management services must attach a current certification and most recent CARF survey report. Per 441 Iowa Administrative Code 24.1(225C), qualified case managers and supervisors are required to have the following qualifications: “(1) a bachelor’s degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or (2) an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.

**MCO**

MCO community-based case managers develop service plans for members receiving HCBS waiver services. MCOs community-based case managers are required to meet all of the qualifications, requirements, and be accredited as specified in 441 Iowa Administrative Code Chapter 24 regarding the accreditation of providers of services to persons with mental illness, intellectual disability; and developmental disabilities.

**Social Worker**

*Specify qualifications:*

**Other**

*Specify the individuals and their qualifications:*

Integrated Health Homes, through their Care Coordinators, are responsible for service planning functions for those members enrolled with an IHH. IHH care coordinators must meet the requirements as outlined in the approved Health Home SPA Attachment H, SPMI: The Care Coordinator must be a BSW with an active license, or BS/BA in the related field.

**Appendix D: Participant-Centered Planning and Service Delivery**

**D-1: Service Plan Development (2 of 8)**

**b. Service Plan Development Safeguards. *Select one:***

**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

**Appendix D: Participant-Centered Planning and Service Delivery**

**D-1: Service Plan Development (3 of 8)**

**c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the**

service plan development process and (b) the participant's authority to determine who is included in the process.

Information related to waiver services and general waiver descriptions are initially made available following receipt of a waiver application. Service plans are then developed with the member and an interdisciplinary team, regardless of delivery system. Teams often consist of the member and, if appropriate, their representative; case manager, health home coordinator, or community-based case manager; service providers; and other supporting persons selected by the member. During service plan development, the member and/or their representative is strongly encouraged to engage in an informed choice of services, and is offered a choice of institutional or HCBS. Planning is timely, occurs when convenient for the member, and is intended to reflect the member's cultural considerations. If the member chooses to self-direct services, an Independent Support Broker is provided to assist with budgeting and employer functions.

The IME Member Services Unit remains available at all times, during normal business hours, to answer questions and offer support to all Medicaid members. Further, the Member Services Unit distributes a quarterly newsletter in effort to continually educate waiver members about services and supports that are available but may not have been identified during the service plan development process.

For children ages 0 - 3 CM Comprehensive Assessment (or modified PIHH), for ages 4 – 20 interRAI - Child and Youth Mental Health(ChYMH), and for ages 12 - 18 interRAI - Adolescent Supplement (in addition to ChYMH) is completed prior to the initial eligibility determination and yearly thereafter for fee-for-service (FFS) and MCO members.

The fee-for-service person-centered planning processes must:

- Include people chosen by the member;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the member and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and
- Record the alternative home and community-based settings that were considered by the member.

MCOs are contractually required to provide supports and information that encourage members to direct, and be actively engaged in, the service plan development process, and to ensure that members have the authority to determine who is included in the process. Specifically, MCO person-centered planning processes must:

- Include people chosen by the member;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and Record the alternative home and community-based settings that were considered by the member.

## Appendix D: Participant-Centered Planning and Service Delivery

---

### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

For fee-for-service members, service plans are developed by the member; case manager or health home coordinator; and an interdisciplinary team. Planning meetings are scheduled at times and locations convenient for the member. The service plan must be completed prior to services being delivered and annually thereafter, or whenever there is a significant change in the member's situation or condition. The case manager or health home coordinator receives the assessment and level of care determination from medical services. A summary of the assessment becomes part of the service plan. The case manager or health home coordinator uses information gathered from the assessment and then works with the member to identify individual and family strengths, needs, capacities, preferences and desired outcomes and health status and risk factors. This is used to identify the scope of services needed.

Note: For both FFS and managed care enrollees, the types of assessments used are identified in Appendix B-6-e.

The case manager or health home coordinator informs the member of all available non-Medicaid and Medicaid services including waiver services. There are waiver informational brochures available to share with members and their parents/guardians. Brochures are available at each of the DHS county offices. Information is also available on the IME and MCO websites. The brochures include information on eligibility, service descriptions, and the application process. Once a member has been granted waiver eligibility and has a case manager, health home coordinator, or community-based case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a member's plan of care.

The member and the interdisciplinary team choose services and supports that meet the member's needs and preferences, which become part of the service plan. Service plans must:

- Reflect that the setting in which the member resides is chosen by the member;
- Reflect the member's strengths and preferences;
- Reflect the clinical and support needs as identified through the needs assessment;
- Include individually identified goals and desired outcomes which are observable and measurable;
- Include the interventions and supports needed to meet member's goals and incremental action steps as appropriate;
- Reflect the services and supports, both paid and unpaid, that will assist the member to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
- Include the identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
- Include a description of any restrictions of the member's rights, including the need for the restriction and a plan to restore the rights (for this purpose, rights include maintenance of personal funds and self-administration of medications);
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Include a plan for emergencies;
- Be understandable to the member receiving services and supports, and the member's important in supporting him or her;
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the member and other people involved in the plan;
- Prevent the provision of unnecessary or inappropriate services and supports.

The case manager or health home coordinator will be responsible for coordination, monitoring and overseeing the implementation of the service plan including Medicaid and non-Medicaid services. If a member chooses to self-direct, the member with the help of a case manager or health home coordinator identifies who will be providing Independent Support Broker Services.

For MCO members, service plans are developed through a person-centered planning process led by the member, with MCO participation, and representatives included in a participatory role as needed and/or defined by the member. Planning meetings are scheduled at times and locations convenient for the member. A team is established to identify services based on the member's needs and desires, as well as availability and appropriateness of services. The team is also responsible for identifying an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or when the member's needs change. Service plans are completed prior to services being delivered, and are reevaluated at least annually, whenever there is a significant change

in the member's situation or condition, or at a member's request.

In accordance with 42 CFR 441.301 and 441 Iowa Administrative Code Chapters 90.5(1)b and 83, MCOs must ensure the service plan reflects the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan must reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports. The service planning process must address the full array of medical and non-medical services and supports provided by the MCO and available in the community to ensure the maximum degree of integration and the best possible health outcomes and participant satisfaction. Services plans must:

- Reflect that the setting in which the member resides is chosen by the member;
- Reflect the member's strengths and preferences;
- Reflect the clinical and support needs as identified through the needs assessment;
- Include individually identified goals and desired outcomes which are observable and measurable;
- Include the interventions and supports needed to meet member's goals and incremental action steps as appropriate;
- Reflect the services and supports, both paid and unpaid, that will assist the member to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
- Include the identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
- Include a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights (for this purpose, rights include maintenance of personal funds and self-administration of medications);
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Include a plan for emergencies;
- Be understandable to the member receiving services and supports, and the members important in supporting him or her;
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the member and other people involved in the plan;
- Prevent the provision of unnecessary or inappropriate services and supports.

MCO members have appeal rights, including access to a State Fair Hearing after exhausting the MCO appeal process. Members can continue services while an appeal decision is pending, when the conditions of 42 CFR 438.420 are met. MCOs are contractually required to implement a comprehensive strategy to ensure a seamless transition of services during program implementation. Further, MCOs are required to develop and maintain, subject to DHS approval, a strategy and timeline within which all waiver members will receive an in-person visit from appropriate MCO staff and an updated needs assessment and service plan. Services may not be reduced, modified or terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. Changes to these must receive DHS prior approval.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the evaluation/reevaluation of level of care, risks are assessed for FFS members by a case manager or integrated health home care coordinator, and for MCO members by their respective MCO, using the assessment tools designated in B-6e. The assessment becomes part of the service plan and any risks are addressed as part of the service plan development process. The comprehensive service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. In addition, providers of applicable services shall provide for emergency backup staff. All service plans must include a plan for emergencies and identification of the supports available to the participant in an emergency.

Risk assessments and mitigation plans are completed during the individual's service plan (ISP) team meeting. The IHH determines a member's risk through a series of questions and answers. Findings are documented on in the Person Centered Treatment Plan. This form guides the IHH to identify member's personal preferences for risk mitigation including back-up arrangements. The IHH Care Coordinator leads the ISP meeting, ensuring that there is a back-up arrangement for each service identified. The member, ISP team members, and ancillary providers receive a copy of the plan.

Emergencies are those situations for which no approved individual program plan exists and which, if not addressed, may result in injury or harm to the participant or other persons or significant amounts of property damage. The service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. In addition providers of applicable services shall provide for emergency backup staff.

Emergency plans are developed on the following basis:

- Providers must provide for emergency, back-up staff in applicable services.
- Interdisciplinary teams must identify in the service plan, as appropriate for the individual member health and safety issues based on information gathered prior to the team meeting, including a risk assessment. This information is incorporated into the service plan.
- The team identifies an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or the member's needs change.

The IME has developed a computer program named the Individualized Services Information System (ISIS) to support HCBS programs. For fee-for-service members, this system assists the Medicaid Agency and the case manager or health home coordinator with tracking information, and monitoring and approving the service plan. Through ISIS, the case manager or health home coordinator authorizes service and service payments on behalf of the member. There are certain points in ISIS process that require contacting the designated DHS central office personnel. The case manager and health home coordinator are responsible for the development the service plan and the service plan is authorized through ISIS, which is the Medicaid Agency. (Refer to appendix A and H for ISIS system processes.)

MCOs have processes to ensure the necessary risk assessments and mitigation plans are completed and made available to all parties.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

While information about qualified and accessible providers is available to members through the IME website, MCO website, and/or MCO member services call center, the case manager, health home coordinator, or community-based case manager first identifies providers to the member and their interdisciplinary team during the person-centered service planning process. Members are encouraged to meet with available providers before making a selection, and members are not restricted to choosing providers within their community. Information about qualified and accessible providers is also available to members through their case manager, health home coordinator, community-based case manager, IME website, and/or MCO website. If an MCO is unable to provide services to a particular member using contract providers, the MCO is required to adequately and timely cover these services for that member using non-contract providers, for as long as the MCO's provider network is unable to provide them.

The MCOs are responsible for authorizing services for out-of-network care when they do not have an in-network provider available within the contractually required time, distance and appointment availability standards. The MCO is responsible for assisting the member in locating an out-of-network provider, authorizing the service and assisting the member in accessing the service. The MCO will also assist with assuring continuity of care when an in-network provider becomes available. To ensure robust provider networks for members to choose from, MCOs are not permitted to close provider networks until adequacy is fully demonstrated to, and approved by, the State. Further, members will be permitted to change MCOs to the extent their provider does not ultimately contract with their MCO. Finally, MCOs are required to submit to the State on a regular basis provider network reports including, but not limited to network geo-access reports, 24-hour availability audit reports, provider-credentialing reports, subcontractor compliance summary reports, and provider helpline performance reports.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DHS has developed a computer program named the Individualized Services Information System (ISIS) to support HCBS programs. This system assists DHS with tracking information, monitoring, and approving service plans for fee-for-service members. (Refer to appendix A and H for ISIS system processes.) On a monthly basis, the IME MSU conducts service plan reviews. The selection size for the waiver has a 95% confidence level. This info is reported to CMS as part of Iowa's performance measures. The State retains oversight of the MCO service plan process through a variety of monitoring and oversight strategies as described in Appendix D – Quality Improvement: Service Plan section. ISIS will only be utilized for fee-for-service members and quality data for managed care participants will be provided by the MCOs.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

**Every three months or more frequently when necessary**

**Every six months or more frequently when necessary**

**Every twelve months or more frequently when necessary**

**Other schedule**

*Specify the other schedule:*

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a

minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

**Medicaid agency**

**Operating agency**

**Case manager**

**Other**

*Specify:*

Targeted Case managers, or health home coordinators, maintain fee-for-service member service plans. MCO community-based case managers maintain MCO member service plans.

## **Appendix D: Participant-Centered Planning and Service Delivery**

---

### **D-2: Service Plan Implementation and Monitoring**

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

#### FFS Members

DHS is responsible for monitoring the implementation of the service plan and the health and welfare of fee-for-service members, including:

- Monitoring service utilization.
- Making at least one contact per month with the member, the member's legal representative, the member's family, service providers, or another person, as necessary to develop or monitor the treatment plan.
- Make a face-to-face contact with the member at least once every three months.
- Participating in the development and approval of the service plan in coordination with the interdisciplinary team at least annually or as needs change. If services have not been meeting member's needs the plan is changed to meet those needs. The effectiveness of the emergency backup plan is also addressed as the service plan is developed.

The member is encouraged during the time of the service plan development to call the case manager or health home coordinator if there are any problems with either Medicaid or non-Medicaid services. The case manager or health home coordinator will then follow up to solve any problems. Monitoring service utilization includes verifying that:

- The member used the waiver service at least once a calendar quarter.
- The services were provided in accordance with the plan.
- The member is receiving the level of service needed.

The ISIS system is also used to assist with tracking information, monitoring services, and assuring services were provided to fee-for-service members. If the member is not receiving services according to the plan or not receiving the services needed, the member and other interdisciplinary team members and providers are contacted immediately.

HCBS specialists monitor the health and welfare, service plan implementation, and case manager or health home coordinator involvement during the home and community quality assurance review process. Members are asked about their choice of provider, whether or not the services are meeting their needs, whether staff and care coordinators are respecting their choice and dignity, if they are satisfied with their services and providers, or whether they feel safe where they receive services and live.

HCBS specialists also review the effectiveness of emergency back-up and crisis plans. These components are monitored through quality oversight reviews of providers, member satisfaction surveys, complaint investigation, and critical incident report follow-up. All providers are reviewed at least once over a five-year cycle and members are surveyed at a 95% confidence level. Information about monitoring results are compiled by the HCBS Quality Assurance and Technical Assistance Unit on a quarterly basis. This information is used to make recommendations for improvements and training.

The IME MSU also conducts quality assurance reviews of member service plans at a 95% confidence level. These reviews focus on the plan development, implementation, monitoring, and documentation that is completed by the case manager or health home coordinator. All service plans reviewed are assessed for member participation, whether the member needs are accurately identified and addressed, the effectiveness of risk assessments and crisis plans, member access to waiver and non-waiver services, as well as coordination across providers to best serve the member's needs. Information about monitoring results are compiled by the IME MSU on a quarterly basis. This information is used to make recommendations for improvements and training.

#### MCO Members

MCOs are responsible for monitoring the implementation of the service plan, including access to waiver and non-waiver services, the quality of service delivery, and the health, safety and welfare of members and choice of providers. After the initiation of services identified in a member's service plan, MCOs monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan. At minimum, the community based case manager must contact members within five business days of scheduled initiation of services to confirm that services are being provided and that member's needs are being met. At a minimum, the community-based case manager shall contact 1915(c) HCBS waiver members at least monthly either in person or by telephone with an interval of at least fourteen (14) calendar days between contacts. Members shall be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least sixty (60) days between visits.

MCOs also identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively. If problems are identified, MCOs complete a self-assessment to determine what additional supports, if any, could be made available to assist the member. MCOs must develop methods for prompt follow-up and remediation of identified problems; policies and procedures regarding required timeframes for follow-up and remediation must be

submitted to DHS for review and approval. Finally, any changes to a member's risk are identified through an update to the member's risk agreement. MCOs must report on monitoring results to the State.

In the event of non-compliance with service plan timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues.

If the MCO fails to develop a plan of care for HCBS waiver enrollees within the timeframe mutually agreed upon between the MCO and the Agency in the course of Contract negotiations the MCO will be assessed a noncompliance fee of \$315 per occurrence.

UnitedHealthCare (UHC) verifies services are furnished in accordance with the individual's service plan through retrospective audits of member records. The Integrated Health Homes are expected to utilize UHC's Person Centered Treatment Plan (PCTP) for CMH members. The PCTP verifies that the participant has full access to waiver services that were identified in the service plan. The PCTP also verifies the member has the right to freely choose the provider, and that the services meet the member's needs. UHC monitors back-up plans and the effectiveness of the plans via retrospective audits. The Integrated Health Home monitors and reports participant's health and welfare through a minimum monthly contact, and through the individual's service planning team meeting. The UHC PCTP is used to document a participant's access to non-waiver services, including health services.

UHC monitors service plans through a retrospective chart audit. 10 records are randomly selected from each IHH on a quarterly basis. Additional audits may be conducted at any time, especially following an audit as proof of remediation. Audit results are shared with the UHC Leadership Team. Results are reviewed with the Integrated Health Homes during monthly Joint Operating Committee meetings. UHC will escalate problems to the State as necessary through the Health Plan leadership and/or the UHC Director of Behavior Health. UHC may place an IHH on a corrective action plan (CAP) as needed, with a goal of a remediation plan and evidence of sustained process improvement.

Amerigroup (AGP) uses multiple data systems to assist with tracking information, monitoring services, and assuring services were provided to participants. If the participant is not receiving services according to the plan or not receiving the services needed, the integrated health home community-based case manager (IHH CBCM) is contacted immediately. The AGP health home and quality management department team members monitor the health and welfare, service plan implementation, and IHH CBCM involvement through a quality assurance review process. This includes ensuring that services are furnished in accordance with the individual's service plan, participants have full access to waiver and non-waiver or health services identified in the service plan, participants can exercise their rights to free choice of provider, whether or not the services are meeting their needs, whether they feel safe where they receive services and live, if they are satisfied with their services and providers, and whether provider and IHH CBCM staff are respecting their choice and dignity. AGP also reviews the effectiveness of emergency back-up and crisis plans. These components are monitored through quality oversight reviews of providers, member satisfaction surveys, complaint investigation, and critical incident report follow-up. All providers are reviewed at least once over a five-year cycle and participants are surveyed at a 95% confidence level. Information about monitoring results are compiled on a quarterly basis and is reported to the State. This information is also used to make recommendations for improvements and training.

After the initiation of services identified in a member's service plan, AGP monitors the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan. At minimum, the IHH CBCM must contact members within five business days of scheduled initiation of services to confirm that services are being provided and that member's needs are being met. At a minimum, the IHH CBCM shall contact 1915(c) HCBS waiver members at least monthly either in person or by telephone with an interval of at least fourteen (14) calendar days between contacts. Members shall be visited in their residence face-to-face by their IHH CBCM at least quarterly with an interval of at least sixty (60) days between visits. AGP also identifies and addresses service gaps and ensures that back-up plans are being implemented and are functioning effectively. If problems are identified, AGP works with the IHH CBCM to complete a member assessment to determine what additional supports, if any, could be made available to assist the member. AGP monitors the follow-up and remediation of identified problems and has policies and procedures regarding required timeframes for follow-up and remediation submitted to DHS. Finally, any changes to a member's risk are identified through an update to the member's risk agreement. AGP reports on monitoring results to the State.

In the event of non-compliance with service plan timelines identified through the its monitoring process, Amerigroup works with the IHH CBCM, provider and member to remediate all individual findings. This may include the assignment of internal Amerigroup case management to oversee and assist in the remediation activities. Amerigroup follows State-dictated standards and timeframes in the systematic collection of information and regular reporting of results, trend findings and remediation results.

**b. Monitoring Safeguards.** *Select one:*

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

**a. Methods for Discovery: Service Plan Assurance/Sub-assurances**

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

**i. Sub-Assurances:**

**a. Sub-assurance:** *Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**SP-a: The IME shall measure the number and percent of service plans that accurately reflect the member's assessed needs. The assessed needs must include, at a minimum, personal goals, health risks, and safety risks. Numerator = # of service plans that address all member assessed needs including health and safety risks, and personal goals. Denominator = # of reviewed service plans.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

**person-centered plans and the results of the department approved assessment**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% +/- 5%</div>
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 2px; width: fit-content;">Contracted Entity and MCOs</div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; padding: 2px;">                         IA.0299 - BI (6%)                          IA.0213- AIDS/HIV (.05%)                          IA.0242 - ID (47%)                          IA.0345 - PD (4%)                          IA.0819 - CMH (4%)                          IA.4111 - HD (9%)                          IA.4155 - Elderly (30%)                     </div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="405 577 798 658" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="868 864 1260 945" type="text"/>

**b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**SP-c2: The IME will measure the number and percent of service plans which are**

**updated on or before the member's annual due date. Numerator = # of service plans updated prior to due date; Denominator = # of service plans reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

**person-centered plans and the results of the department approved assessment**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95% +/- 5%</div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 10px;">contractor entity and MCOs</div>	Annually	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; padding: 2px; margin-top: 10px;">                         IA.0299 - BI (6%)                          IA.0213- AIDS/HIV (.05%)                          IA.0242 - ID (47%)                          IA.0345 - PD (4%)                          IA.0819 - CMH (4%)                          IA.4111 - HD (9%)                          IA.4155 - Elderly (30%)                     </div>
	Continuously and Ongoing	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

**Performance Measure:**

**SP-c1: The IME will measure the number and percent of service plans which were revised when warranted by a change in the member’s needs. Numerator = # of service plans updated or revised when warranted by changes to the member’s needs. Denominator = # of reviewed service plans that indicate a change in member’s needs.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

**person-centered plans and the results of the department approved assessment**

Responsible Party for data collection/generation ( <i>check each that applies</i> ):	Frequency of data collection/generation ( <i>check each that applies</i> ):	Sampling Approach ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative</b>

		<p><b>Sample</b> Confidence Interval =</p> <p>95% +/- 5%</p>
<p><b>Other</b> Specify:</p> <p>Contracted Entity and MCOs</p>	<p><b>Annually</b></p>	<p><b>Stratified</b> Describe Group:</p> <p>IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)</p>
	<p><b>Continuously and Ongoing</b></p>	<p><b>Other</b> Specify:</p>
	<p><b>Other</b> Specify:</p>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**SP-d1: The IME will measure the number and percent of members' service plans that identify type, scope & frequency of all services authorized in the service plan**

**Numerator: # members service plans that identify type, scope and frequency of all services authorized in the service plan Denominator = # of service plans reviewed**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

**Service plans are requested from the case managers, with service provision documentation requested from providers.**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b>

		Confidence Interval = <input type="text" value="95% +/- 5%"/>
<b>Other</b> Specify: <input type="text" value="Contracted Entity and MCOs"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text" value="IA.0299 - BI (6%)&lt;br/&gt;IA.0213- AIDS/HIV (.05%)&lt;br/&gt;IA.0242 - ID (47%)&lt;br/&gt;IA.0345 - PD (4%)&lt;br/&gt;IA.0819 - CMH (4%)&lt;br/&gt;IA.4111 - HD (9%)&lt;br/&gt;IA.4155 - Elderly (30%)"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**SP-e1 The IME will measure the number and percentage of members from the HCBS IPES who responded that they had a choice of services. Numerator = # of IPES respondents who responded that they had a choice of services; Denominator = # of IPES respondents that answered the question asking if they had a choice of services**

**Data Source** (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

**FFS HCBS UNIT QA survey data and MCO IPES databases**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		95% +/- 5%
<b>Other</b> Specify:  Medicaid contractor entity and MCO	<b>Annually</b>	<b>Stratified</b> Describe Group:  IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b> Specify:  	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**SP-e2: The IME will measure the number and percentage of service plans from the HCBS QA survey review that indicated the member had a choice of providers.**

**Numerator: The total number of service plans reviewed which demonstrate choice of HCBS service providers; Denominator: The total number of service plans reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

**FFS QA review of service plan stored in OnBase. MCO review service plans available through their systems.**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95% +/- 5%</div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; display: inline-block; margin-top: 5px;">contracted entity and MCO</div>	<b>Annually</b>	<b>Stratified</b> Describe Group:

		IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify:	<input type="text"/>

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. MCOs are responsible for oversight of service plans for their members.

In reference to SP-e1, if member answers ‘ No or I don’t know’ to this IPES question, a follow-up letter is sent to the case manager to ensure member is participating in Person Centered Planning. Person Centered Planning is also monitored by the HCBS QA Unit through the MCO Community Based Case Managed (CMCB) Interdisciplinary Team (IDT) Ride Alongs process. The QA staff participates in a random selection of IDT meetings and then follows up to ensure that the final authorized plan agrees with the plan agreed upon by the IDT.

General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. MCOs are responsible for oversight of service plans for their members.

In reference to SP-e1, if member answers ‘No or I don’t know’ to this IPES question, a follow-up letter is sent to the case manager to ensure member is participating in Person Centered Planning. Person Centered Planning is also monitored by the HCBS QA Unit through the MCO Community Based Case Managed (CMCB) Interdisciplinary Team (IDT) Ride Alongs process. The QA staff participates in a random selection of IDT meetings and then follows up to ensure that the final authorized plan agrees with the plan agreed upon by the IDT.

General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Contracted Entity and MCOs	
	<input type="checkbox"/> Continuously and Ongoing
	Other Specify:  <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix E: Participant Direction of Services**

---

**Applicability** *(from Application Section 3, Components of the Waiver Request):*

**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one):*

**Yes. The state requests that this waiver be considered for Independence Plus designation.**

**No. Independence Plus designation is not requested.**

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (1 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (2 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (3 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (4 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (5 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (6 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (7 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (8 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (9 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (10 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (11 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (12 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (13 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-2: Opportunities for Participant Direction (1 of 6)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-2: Opportunities for Participant-Direction (2 of 6)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-2: Opportunities for Participant-Direction (3 of 6)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-2: Opportunities for Participant-Direction (4 of 6)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-2: Opportunities for Participant-Direction (5 of 6)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-2: Opportunities for Participant-Direction (6 of 6)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix F: Participant Rights**

---

**Appendix F-1: Opportunity to Request a Fair Hearing**

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Application Process for both FFS and MCO enrolled members:

Members are given an oral explanation of the appeals (State Fair Hearing) process during the application process by the Iowa Department of Human Services (DHS) income maintenance staff. The responsibility to explain the right to request a State Fair Hearing for choice between institutional care vs. HCBS is the responsibility of the state's Income Maintenance worker at the time of waiver application; this action is not the responsibility of the MCO.

The Department also gives members an oral explanation at the time of any contemplated adverse benefit determination. Depending on the adverse benefit determination, this could be provided by the income maintenance worker, case manager, integrated health care coordinator, community-based case manager, and/or medical provider performing the level of care determination. The member is also given written notice of the following at the time of application; and, at the time of any department adverse benefit determination. An adverse benefit determination affects a claim for assistance in which applicants are not provided the choice of home and community based services as an alternative to institutional care and members are denied services or providers of their choice, or whose services are denied, suspended, reduced or terminated.

An adverse benefit determination notice of determination that results in members' right to appeal includes the following elements: the right to request a hearing, the procedure for requesting a hearing, the right to be represented by others at the hearing, unless otherwise specified by the statute or federal regulation, provisions for payment of legal fees by DHS; and how to obtain assistance, including the right to continue services while an appeal is pending.

The choice of HCBS vs. institutional services is discussed with the member at the time of the completion of the application by DHS income maintenance staff ; and again at the time of the service plan development by the case manager, integrated health care coordinator, or community-based case manager.

All DHS application forms, notices, pamphlets and brochures contain information on the appeals process and the opportunity to request an appeal. This information is available at all of the local offices and on the DHS website. The process for filing an appeal can be found on all Notices of Decision (NOD). Procedures regarding the appeal hearing can be found on the Notice of Hearing. As stated in Iowa Administrative Code, any person or group of persons may file an appeal with DHS concerning any decision, made. The member is encouraged, but not required, to make a written appeal on a standard Appeal and Request a Hearing form. Appeals may also be filed via the DHS website. If the member is unwilling to complete the form, the member would need to request the appeal in writing.

All notices are kept at all local DHS Offices or the case manager, integrated health care coordinator, or community-based case manager's file. The member is given their appeal rights in writing, which explains their right to continue with their current services while the appeal is under consideration. Copies of all notices for a change in service are maintained in the service file. IME reviews this information during case reviews.

#### MANAGED CARE ORGANIZATIONS:

When an HCBS member is assigned to a specific MCO, the assigned MCO community based case manager explains the member's appeal rights through the Fair Hearing process during the initial intake process. The responsibility to explain the right to request a State Fair Hearing for choice between institutional care vs. HCBS is the responsibility of the state's Income Maintenance worker at the time of waiver application; this action is not the responsibility of the MCO.

The MCOs keep the notifications as indicated here:

Amerigroup: Notices are sent to requesting provider, member, and a copy is stored in online member medical record file.  
UnitedHealthCare: Notices of adverse action (which outline a member's rights to Fair Hearing) are housed within specified documentation storage systems based on service/case type. These systems include: Linx, ECAA, and ETS.

In accordance with 42 CFR 438, an adverse benefit determination means any of the following:

- (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- (2) The reduction, suspension, or termination of a previously authorized service.
- (3) The denial, in whole or in part, of payment for a service. (4) The failure to provide services in a timely manner, as defined by the State.
- (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
- (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

In accordance with 42 CFR 438, an appeal means a review by an MCO of an adverse benefit determination that it has issued.

MCOs give their members written notice of all adverse benefit determinations, not only service authorization adverse benefit determinations, in accordance with state and federal rules, regulations and policies, including but not limited to 42 CFR 438. MCO enrollment materials must contain all information for appeals rights as delineated in 42 CFR 438.10, including: (A) the right to file an appeal; (B) requirements and timeframes for filing an appeal; (C) the availability of assistance in the filing process; (D) the right to request a State Fair Hearing after the MCO has made a determination of a member's internal MCO appeal which is adverse to the member. The fact that, if requested by the member, benefits that the MCO seeks to reduce or terminate will continue if the member files an appeal or requests a State fair hearing within the specified timeframe and that the member may be required to pay the cost of such services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the member.

MCOs must provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to providing interpreter services, and toll-free numbers that have adequate TTY/TTD and interpreter capability. Upon determination of the appeal, the MCO must ensure there is no delay in notification or mailing to the member and member representative the appeal decision. The MCO's appeal decision notice must describe the adverse benefit determinations taken, the reasons for the adverse benefit determination, the member's right to request a State fair hearing, process for filing a fair hearing and other information set forth in 42 CFR 438.408(e).

MCOs must maintain an expedited appeals process when the standard time for appeal could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain or regain maximum function. The MCO must also provide general and targeted education to members and providers regarding expedited appeals including when an expedited appeal is appropriate and procedures for providing written certification thereof.

The MCO's appeal process must conform to the following requirements:

- Allow members, or providers acting on the member's behalf, sixty (60) calendar days from the date of adverse benefit determination notice within which to file an appeal.
- In accordance with 42 CFR 438.402, ensure that oral requests seeking to appeal an adverse benefit determination are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.
- The MCO must dispose of expedited appeals within 72 hours after the Contractor receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c).
- In accordance with 42 CFR 438.410, if the MCO denies the request for an expedited resolution of a member's appeal, the MCO must transfer the appeal to the standard thirty (30) calendar day timeframe and give the member written notice of the denial within two (2) calendar days of the expedited appeal request. The MCO must also make a reasonable attempt to give the member prompt oral notice.
- The MCO must acknowledge receipt of each standard appeal within three (3) business days.
- The MCO must make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 CFR 438.408. If the timeframe is extended, for any extension not requested by the member, the MCO must give the member written notice of the reason for the delay.
- In accordance with 42 CFR 438.408, written notice of appeal disposition must be provided with citation of the Iowa Code and/or Iowa Administrative Code sections supporting the adverse benefit determination in non-authorization and care review letters that advise members of the right to appeal. For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice. The written notice of the resolution must include the results of the resolution and the date it was completed. For appeals not resolved wholly in favor of the member, the written notice must include the right to request a State fair hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. The MCO shall direct the member to the Agency Appeal and Request for Hearing form as an option for submitting a request for an appeal. This shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds the Contractor's adverse benefit determination.

Members enrolled in an MCO must exhaust the entity's internal grievance processes before pursuing a State Fair

Hearing. This requirement is outlined in the concurrent §1915(b) waiver, Part IV, Section E.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Each MCO operates its own internal grievance and dispute resolution processes. In accordance to 42 CFR 438.408(f), a managed care enrollee may request a State Fair Hearing only after receiving notice that the MCO is upholding the adverse benefit determination.

The policies and procedures regarding the MCO grievance and appeals system are outlined in the concurrent §1915(b) waiver, Part IV, Section E. MCO members can appeal any adverse benefit determination within 60 calendar days. An adverse benefit determination is defined as the: (i) denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) reduction, suspension or termination of a previously authorized service; (iii) denial, in whole or in part, of payment for a service; (iv) failure to provide services in a timely manner; (v) failure of the MCO to act within the required timeframes; or (vi) the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities. MCOs must ensure that oral requests seeking to appeal an adverse benefit determination are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution. MCOs must make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 C.F.R. § 438.408. Expedited appeals must be disposed within seventy-two (72) hours unless the timeframe is extended pursuant to 42 CFR § 438.408 and 410. MCO members can also file grievances with their MCO; grievances are any written or verbal expression of dissatisfaction about any matter other than an adverse benefit determination." MCO members have the right to request a State Fair Hearing if dissatisfied with the outcome of the MCO appeals process. MCOs notify members of this right through enrollment materials and notices of adverse benefit determination, including information that the MCO grievance and appeals process is not a substitute for a Fair Hearing. MCOs must acknowledge receipt of a grievance within three (3) business days and must make a decision on grievances and provide written notice of the disposition of grievance within thirty (30) calendar days of receipt of the grievance or as expeditiously as the member's health condition requires. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 C.F.R. § 438.408.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

**FEE FOR SERVICE:**

IME is responsible for operation of the complaint and grievance reporting process for all fee-for-service members. In addition, the Department maintains an HCBS Quality Assurance and Technical Assistance Unit contract that is responsible for the handling of fee-for-service member complaints and grievances in regards to provision of services under this waiver.

**MANAGED CARE ORGANIZATION:**

IME Member Services MCO Member and MCO Liaison: Designated IME Member Services staff serves as a liaison for any MCO grievance/complaint that is reported to IME Policy staff by an MCO member or his/her advocate. IME Policy sends the pertinent details of the grievance/complaint to the MCO liaison. The IME MCO liaison communicates and coordinates with the MCO and member to grievance/complaint to resolution; and, the resolution is communicated to the IME Policy staff who received the original grievance/complaint. This process serves to support those MCO members who may be confused about the MCO grievance/complaint process to follow or members who have not been able to resolve their grievance/complaint with their MCOs.

Grievances/complaints follow the parameters and timelines in accordance with 42 CFR 438.408 and 438.410.

A grievance/complaint means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision.

**MCO Grievance/Complaint System:**

The MCO must provide information about its grievance/complaint system to all providers and subcontractors at the time they enter into a contract. Further, the MCO is responsible for maintenance of grievance records in accordance with 42 CFR 438.416.

The MCO must provide information about its grievance/complaint system to all members and provide reasonable assistance in completing forms and taking procedural steps. This responsibility also includes; but is not limited to, auxiliary aids and services upon request (e.g. interpreter services and toll-free numbers that have TTY/TTD and interpreter capability).

The MCO member handbook must include information, consistent with 42 CFR 38.10.

The MCO must insure that individuals who make decisions on grievances have not been involved in any previous level of review or decision-making and is not a subordinate of such individual.

**MCO Grievance/Complaint Process:**

A member may submit an oral or written grievance at any time to the MCO. With written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. There is not a timeline for submission.

The MCO must acknowledge receipt of the grievance.

The MCO must process the grievance resolution within 30 days of the date that the grievance is received and issue a written notification to the member in accordance with 42 CFR 438.408.

The resolution may be extended by fourteen (14) days upon member request. If the member does not request an extension, the MCO must make reasonable efforts to give the member prompt oral notice of the delay; and within two (2) calendar days provide the member with a written notice of the basis for the decision to extend the timeframe. If the member does not agree with the extension, he/she may file an additional grievance to the extension.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that

are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Any fee-for-service waiver member, member's relative/guardian, agency staff, concerned citizen or other public agency staff may report a complaint regarding the care, treatment, and services provided to a member. A complaint may be submitted in writing, in person, by e-mail or by telephone. Verbal reports may require submission of a detailed written report. The complaint may be submitted to an HCBS Provider Quality Oversight Specialist, HCBS Program Manager, any IME Unit, or Bureau Chief of Long Term Care. Complaints by phone can be made to a regional HCBS Provider Quality Assurance Oversight Specialist at their local number or by calling the IME. The Bureau of Long Term Care has established a committee to review complaints. The committee will meet biweekly to review current complaints.

Once received, the HCBS Quality Assurance and Technical Assistance Unit shall initiate investigation within one business day of receipt and shall submit a findings report to the Quality Assurance Manager within 15 days of finalizing the investigation. Once approved by the Quality Assurance Manager, the findings report is provided to the complainant and the provider in question. If the complainant is a member, they are informed by the HCBS Quality Assurance and Technical Assistance Unit Incident and Complaint Specialist that filing a grievance or making a complaint is not a prerequisite or substitute for a Fair Hearing.

MCO members must exhaust the entity's internal grievance and appeals processes before pursuing a State Fair Hearing. The policies and procedures regarding the MCO grievance and appeals system are outlined in the concurrent §1915(b) waiver, Part IV, Section E. MCO members can appeal any "action" within 60 days. An "action" is defined as the: (i) denial or limited authorization of a requested service, including the type or level of service; (ii) reduction, suspension or termination of a previously authorized service; (iii) denial, in whole or in part, of payment for a service; (iv) failure to provide services in a timely manner; or (v) failure of the MCO to act within the required timeframes set forth in 42 CFR 438.408(b). In accordance with 42 CFR 438.406, oral requests seeking an appeal are treated by the MCO as an appeal; however, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.

MCO members have the right to request a State Fair Hearing if dissatisfied with the outcome of the MCO appeals process. MCOs notify members of this right through enrollment materials and notices of action. In accordance with 42 CFR 438.406, the MCO provides the member and their representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents or records considered during the appeals process. In addition, the member and their representative have the opportunity to present evidence and allegations of fact or law in person as well as in writing. Upon determination of the appeal, the MCO must promptly notify the member and his/her representative of the appeal decision. The MCO's appeal decision notice must describe the actions taken, the reasons for the action, the member's right to request a State Fair Hearing, process for filing a Fair Hearing and other information set forth in 42 CFR 438.408(e).

MCOs must ensure that the individuals rendering decisions on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with appropriate clinical expertise in treating the member's condition or disease if the decision will be in regard to any of the following: (i) an appeal of a denial based on lack of medical necessity; (ii) a grievance regarding denial of expedited resolution of an appeal; or (iii) any grievance or appeal involving clinical issues. Appeals must be resolved by the MCO within 30 calendar days of receipt; this timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c).

MCOs must resolve appeals on an expedited basis when the standard time for appeal could seriously jeopardize the member's health or ability to maintain or regain maximum function. Such expedited appeals must be resolved within 72 hours after the MCO receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c). Standard appeals must be resolved within 30 calendar days; this timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c). If the timeframe is extended, for any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay. Within 90 calendar days of the date of notice from the MCO on the appeal decision, the member may request a State Fair Hearing.

MCO members can also file grievances with their MCO; grievances are any written or verbal expression of dissatisfaction about any matter other than an "action," as defined above. Grievances may be filed either orally or in writing; receipt is acknowledged by the MCO within 3 business days and resolved within 30 calendar days or as expeditiously as the member's health condition requires. This timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c).

MCOs are required to track all grievances and appeals in their information systems; this includes data on clinical reviews,

appeals, grievances and complaints and their outcomes. MCOs are responsible for reporting on grievances and appeals to DHS. This includes maintenance and reporting to the State the MCO member grievance and appeals logs which includes the current status of all grievances and appeals and processing timelines.

## Appendix G: Participant Safeguards

---

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

**Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

**No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All waiver service providers, case managers, integrated health home care coordinators, and MCO CBCMs, regardless of delivery system (i.e., FFS or managed care), are required to document major and minor incidents and make the incident reports and related documentation available to DHS upon request. Providers, case managers, integrated health home care coordinators, and MCO CBCMs must also ensure cooperation in providing pertinent information regarding incidents as requested by DHS. MCOs must require that all internal staff and network providers report, respond to, and document critical incidents, as well as cooperate with any investigation conducted by the MCO or outside agency, all in accordance with State requirements for reporting incidents for 1915(c) HCBS Waivers, 1915(i) Habilitation Program, PMICs, and all other incidents required for licensure of programs through the Department of Inspections and Appeals.

Per Chapter 441 Iowa Administrative Code 77.25(1), “major incidents” are defined as an occurrence involving a participant during service provision that: (1) results in a physical injury to or by the participant that requires a physician’s treatment or admission to a hospital; (2) results in the death of any person; (3) requires emergency mental health treatment for the participant; (4) requires the intervention of law enforcement; (5) requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; (6) constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or (7) involves a participant’s location being unknown by provider staff who are assigned protective oversight. All major incidents must be reported within 48 hours of witnessing or discovering an incident has occurred, using the IME’s Iowa Medicaid Portal Access (IMPA) System. Suspected abuse or neglect may be reported to the statewide abuse reporting hotline operated by DHS.

Child and dependent adult abuse is an inclusive definition that includes physical and sexual abuse, neglect and exploitation. Child abuse is defined in Iowa Code 232.68, and may include any of the following types of acts of willful or negligent acts or omissions:

- Any non-accidental physical injury.
- Any mental injury to a child’s intellectual or psychological capacity.
- Commission of a sexual offense with or to a child.
- Failure on the part of a person responsible for the care of a child to provide adequate food, shelter, clothing or other care necessary for the child’s health and welfare.
- Presence of an illegal drug in a child’s body as a direct act or omission of the person responsible for the care of a child or manufacturing of a dangerous substance in the presence of a child.

Dependent adult abuse is defined in Iowa Code 235B.2, and may include any of the following types of acts of willful or negligent acts or omissions:

- Physical injury or unreasonable confinement, unreasonable punishment, or assault of a dependent adult.
- Commission of a sexual offense or sexual exploitation.
- Exploitation of a dependent adult.
- Deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care or other care necessary to maintain a dependent adult’s life or health.

When a major incident occurs, provider staff must notify the member or the member’s legal guardian within 24 hours of the incident and distribute a complete incident report form as follows:

- Forward a copy to the supervisor with 24 hours of the incident.
- Send a copy of the report to the member’s case manager, health home coordinator, or community-based case manager (when applicable) and the BLTC within 24 hours of the incident.
- File a copy of the report in a centralized location and make a notation in the member’s file.

Per Chapter 441 Iowa Administrative Code 77.25(1), “minor incidents” are defined as an occurrence involving a participant during service provision that is not a major incident and that: (1) results in the application of basic first aid; (2) results in bruising; (3) results in seizure activity; (4) results in injury to self, to others, or to property; or (5) constitutes a prescription medication error. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider’s system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the member’s file.

As part of the quality assurance policies and procedures for HCBS Waivers, all incidents will be monitored and remediated by the HCBS Incident Reporting Specialist and HCBS specialists. On a quarterly basis, a QA committee will review data collected on incidents and will analyze data to determine trends, problems and issues in service delivery and make recommendations of any policy changes.

MCOs are also required to develop and implement a critical incident management system in accordance with DHS requirements, in addition to maintaining policies and procedures that address and respond to incidents, remediate the incidents to the individual level, report incidents to the appropriate entities per required timeframes, and track and analyze incidents.

MCOs must adhere to the State's quality improvement strategy described in each HCBS waiver and waiver-specific methods for discovery and remediation. MCOs must utilize system information to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. All MCO staff and network providers are required to:

- Report critical incidents.
- Respond to critical incidents.
- Document critical incidents.
- Cooperate with any investigation conducted by the HCBS Quality Assurance and Technical Assistance Unit staff, MCO, or outside agency.
- Receive and provide training on critical incident policies and procedures.
- Be subject to corrective action as needed to ensure provider compliance with critical incident requirements.

Finally, MCOs must identify and track critical incidents, and review and analyze critical incidents, to identify and address quality of care and/or health and safety issues, including a regular review of the number and types of incidents and findings from investigations. This data should be used to develop strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information concerning protections is provided to applicants and members at the time of application and at the time of service plan development. During enrollment, and when any updates are made, DHS also provides to members a Medicaid Members Handbook, which contains information regarding filing a complaint or grievance. MCO written member enrollment materials also contain information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect.

In addition, information can also be found on DHS and MCO websites. The DHS website contains a "Report Abuse and Fraud" section, which describes how to report dependent adult child abuse. The same information is also available in written format in the 99 local DHS offices, and members may also call the IME Member Services call center with any questions regarding filing a complaint or grievance.

Finally, the case manager, health home coordinator, or community-based case manager is responsible for assessing a member's risk factors annually during the reevaluation process, as well as during the quality assurance interview process and the annual IPES interview. DHS recognizes the need to provide training to members using on a more formal process. The state has developed training to ensure that case managers, health home coordinators, and community-based case managers provide this information to members at a minimum on a yearly basis.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Reporting of suspected child or adult abuse to DHS Protective Services is mandatory for all IME HCBS staff, case managers, MCO CBCMs, health home care coordinators, and HCBS providers. DHS Protective Services (PS) receives reports of child and dependent adult abuse and, if an immediate threat of physical safety is believed to exist, makes every effort to examine that child or dependent adult within one hour of receipt and/or take any lawful action necessary. If the child or dependent adult is not in danger, PS makes every effort to examine the child or dependent adult within 24 hours. PS notifies the member's case manager, health home coordinator, or community-based case manager when an investigation has been initiated to ensure they are aware of the alleged abuse and to ensure that additional services can be added, or that changes can be made, to the member's plan of care if needed. PS provides an evaluation report within twenty days of receipt of the report, which include necessary actions, and/or an assessment of services needed. The Central Registry of Abuse and County Attorney also receives PS reports. For both child and dependent adult abuse cases, the member and/or the family are notified of the results in writing by DHS as soon as the investigation has concluded. This applies to both individuals enrolled in fee-for-service or managed care.

If the incident is a situation that has caused, or is likely to cause a serious injury, impairment, or abuse to the member, and if PS has completed, or is in the process of conducting, an investigation the HCBS specialist coordinates activities with PS to ensure the safety of the member is addressed. If PS is not investigating, and immediate jeopardy remains, the member's case manager, health home coordinator, or community-based case manager is notified immediately to coordinate services, and the HCBS Specialist initiates a review within two working days of receipt of the report. If it is determined that immediate jeopardy has been removed or not present, review by the HCBS Specialist is initiated within twenty working days of receipt of report. The HCBS Specialist prepares a report of findings within thirty days of the investigation being completed and presents it to the BLTC, the provider, and interested stakeholders (i.e., members, guardians, etc.). These timelines apply to both members enrolled in fee-for-service or managed care.

The BLTC meets biweekly to review critical incident reports of child and dependent adult abuse and member deaths that have been reported through the critical incident reporting process. DHS reviews, and if needed, requests information for follow through and resolution of the abuse allegation and member deaths from the case managers, health home coordinator, community-based case manager, or HCBS Specialist. Requests for information are forwarded to the case manager, health home coordinator, community-based case manager to verify any needed changes and confirm that follow-up has occurred with the member (i.e., changes to a plan of care or the safety or risk plan as necessary). If additional information or actions are required of a provider, the HCBS Specialist works directly with the provider to ensure that performance issues identified in the incident report are addressed. The HCBS Specialist uses the provider's Self-Assessment as the foundation of the review to assure that accuracy in the Self-Assessment and to identify any corrective actions that may be required. The HCBS Specialist generates a report of findings within thirty days of the completion of any review requiring corrective actions.

Information requests to the case manager, health home coordinator, community-based case manager, or HCBS Specialist for follow up are tracked by the HCBS Unit on a weekly basis until the situation has been resolved. DHS implemented a web-based critical incident reporting system September 1, 2009, that significantly enhanced the State's ability to track and trend the discovery, remediation, and improvement of the critical incident reporting process. Revisions have been made to the system based on data collection and feedback from users, further enhancing the process. Incidents are reviewed by the HCBS Quality Oversight Unit within one business day of report and forwarded to the case managers, health home coordinator, community-based case manager as needed to coordinate any follow-up and communication with the member, provider, and/or family/legal guardian. Incidents that lead to targeted review will initiate investigation by the HCBS Quality Oversight Unit within one business day. Findings reports are submitted to the Quality Assurance Manager within 15 days of investigation completion. Once the finding report is approved by the Quality Assurance Manager, the findings report is sent to the provider and case manager, health home coordinator, community-based case manager, or HCBS Specialist.

MCOs are responsible for developing and implementing critical incident management systems in accordance with the DHS requirements. Specifically, MCOs must maintain policies and procedures, subject to DHS review and approval, that: (1) address and respond to incidents; (2) report incidents to the appropriate entities per required timeframes; and (3) track and analyze incidents. This information is utilized to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. Training must be provided to all internal staff and network providers regarding the appropriate procedures for reporting, responding to, and documenting critical incidents. Network providers must provide training to direct care staff regarding the appropriate procedures for reporting, responding to, and documenting critical incidents.

Finally, MCOs must identify and track, review and analyze critical incidents to identify and address quality of care and/or health and safety issues. MCOs must also regularly review the number and types of incidents and findings from investigations, in order to identify trends, patterns, and areas for improvement. Based on these findings, the MCO must develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. Consistent with 441 Iowa Administrative Code 77.25 (3), the following process is followed when a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization or for members not enrolled with a MCO, the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

If the critical incident involves the report of child or dependent adult abuse, it is mandatory that this type of critical incident is reported to DHS Protective Services.

If the critical incident does not involve child or dependent adult abuse, it will be reviewed by the MCO. The MCO will notify the member and/or the family of the results upon conclusion of the investigation, on or within 30 days.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DHS has oversight for monitoring incidents that affect all waiver members. An HCBS Quality Assurance and Technical Assistance Unit reviews all critical incident reports as soon as they are reported to DHS. All critical incidents are tracked in a critical incident database that tracks the date of the event, the specific waiver the member is enrolled in, the provider (if applicable), and the nature of the event, and follow up provided. If the incident has caused or is likely to cause a serious injury, impairment, or abuse to the member, and if PS has completed or is in the process of conducting an investigation, the HCBS Specialist will coordinate with PS. If PS is not investigating, the HCBS Specialist will begin an on-site review within two working days of receipt of the report. If it is determined that the member has been removed from immediate jeopardy, the review is initiated within twenty working days of receipt of report. For other non-jeopardy incidents, a review is initiated within twenty days. The HCBS Quality Assurance and Technical Assistance Unit meets biweekly to review data tracked in the critical incident database and to decide if policy changes or additional training are needed. Data is compiled and analyzed in attempt to prevent future incidents through identification of system and provider specific training needs, and individual service plan revisions.

## Appendix G: Participant Safeguards

**Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)**

**a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

**The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

**i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DHS policy regarding restraints is as follows and applies to all types of restraints that may be used by waiver providers. The policy described in this section applies regardless of delivery system (i.e., FFS or MCO), and MCOs are contractually obligated to adhere.

Restraints include, but are not limited to, personal, chemical, and mechanical methods used for the purpose of controlling the free movement of an individual's body. Chemical restraints are most commonly used to calm an individual down in moments of escalation. Other examples of restraints include, but are not limited to, holding a person down with one's hands, tying an individual to a bed, using a straight jacket or demobilizing wrap. As a rights limitation, the restraint procedures must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of restraints must be documented in a member's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

- The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
- Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
- Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
- Restraint, restriction, and behavioral intervention programs shall be time-limited (maximum one year) and shall be reviewed at least quarterly.
- Corporal punishment and verbal or physical abuse are prohibited."

These safeguards are the same regardless of what restraints are used. All restraints must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Restraint procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

Physical and chemical restraints may be allowed depending on the provider's agency policy to ensure that there is an accompanying behavioral intervention plan, documentation of each instance, and monitoring of its use. These types of restraints must be considered on an individual basis after the interdisciplinary team reviews them, and entered into the written plan of care with specific time lines. If a member were placed in a closed room the time frame would need to be determined on an individual basis and spelled out in the service plan. The provider would need to document the use of this restraint in the member's service file each time it was utilized by staff. The provider would be required to have a written policy approved by DHS on the supervision and monitoring of members placed in a closed room, for example monitoring on a fifteen minute basis to assure the health and welfare of the member.

Restraint procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:

- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
  - A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
  - A list of restraints and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors.
- Restraints and behavioral interventions may only be utilized to teach replacement behaviors when non-

aversive methods of positive support have been ineffective.

- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. Staff must be trained and exhibit proficiency as described below before administering restraints.

An employee's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each employee in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (i) the supervisor's ability to implement the procedure has been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Restraints and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter a member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager, integrated health home coordinator, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements:

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the member's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the individual and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:

- A Restraint and Behavioral Intervention Program that is a part of the written individual service plan developed by the member's case manager, integrated health home coordinator, or community-based case manager, and in the provider plan of care developed for the member.
- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as, and includes, the following components: (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior; (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors; (iii) description of the conditions that precede the behavior in question; (iv) description of what appears to reinforce and maintain the behavior; and (v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Restraints must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All restraints are explained to the member and their legal representative and agreed upon ahead of time.

Unauthorized use of restraints would be detected via:

- interviews with the member, their family and staff and case manager, integrated health home coordinator, or community-based case manager;
- through review of critical incident reports by DHS and member's case manager, integrated health home coordinator, or community-based case manager on a daily basis;
- DHS and case manager, integrated health home coordinator, or community-based case manager review of written documentation authored by provider staff;
- through the annual review activities associated with the provider Self-Assessment process;
- and by reports from any interested party (complaints).

Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the DHS policy for each type of agency identified restraint is observed and member rights are safeguarded. If it is found that a waiver provider is not observing DHS policy or ensuring a member's rights, adverse action is taken by the IME, which may include sanction, termination, required corrective action, etc.

The member's case manager, integrated health home coordinator, or community-based case manager is responsible to monitor individual plans of care including the use of restraints and behavioral interventions.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The IME's HCBS QA unit is responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed. The QA contract monitors all FFS incident reports. In a case where the member has had a restraint which is not in their service plan the incident and complaint specialist follows up. Follow up consists of additional information being requested, a corrective action plan, and verification of compliance. FFS and MCO Case managers are also responsible for reviewing incident reports for their members and ensuring restraints are in alignment with the service plan.

The first line of responsibility for overseeing the use of restraints and ensuring safeguards are in place is the member's case manager, integrated health home coordinator, or community based case manager. The use of restraints must be assessed as needed and identified in the individual member's service plan. The use of restraints would also require the development and implementation of a behavior plan and the plan would be included in the member's service plan. The case manager, integrated health home coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restraints would be addressed with the provider of service and corrected as needed.

The State also contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restraints. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether restraints are appropriately incorporated into the service plan, such that restraints are only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of restraints. For fee-for-service members these reports are entered into IMPA, triggering milestones in ISIS that alert case managers and integrated health home coordinators, and prompting the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of restraints, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

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

Finally, the Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of restraints, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

MCO Community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restraints would be addressed with the provider of service and corrected as needed. In addition, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process

outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.).

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** (*Select one*):

**The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

**The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

## FFS and MCO

A restrictive intervention is an action or procedure that imposes a restriction of movement, that limits a member's movement, access to other individuals, locations or activities, or restricts a member's rights. 441-IAC 77.25(4) describes restrictive interventions as restraints, restrictions and behavioral intervention.

The DHS policy regarding restrictive interventions is as follows, and applies to all types of restrictions that may be used by waiver providers. A restrictive intervention is an action or procedure that limits a member's movement, access to other individuals, locations or activities, or restricts a member's rights. The use of any restrictive interventions as part of the waiver program is treated as rights limitations of the member receiving services. As a rights limitation, the restrictive interventions must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code 83.67(4)).

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures." All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

- a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
- b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
- c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
- d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
- e. Corporal punishment and verbal or physical abuse are prohibited."

These safeguards are the same regardless of what restrictions are used. All restrictions must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Restrictions may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

The case manager, health home coordinator, or community-based case manager has the responsibility to assess the need for the restrictive interventions, identify the specific restrictive intervention, explain why the intervention is being used, identify an intervention plan, monitor the use of the restrictive intervention, and assess and reassess need for continued use. The service plan authorizes the services to be delivered to the member and identifies how they are to be provided. Without the authorization, services cannot be provided to a member.

Providers are required to use the service plan as the basis for the development and implementation of the providers' treatment plan. The provider is responsible for developing a plan to meet the needs of the member and to train all staff on the implementation strategies of the treatment plan, such that the interventions are individualized and in accordance with the previously devised plan. Providers and the case manager, health home coordinator, or community-based case manager are responsible for documenting all behavioral interventions, including restrictive interventions, in the service plan as well as the member's response to the intervention. Providers and case manager, health home coordinator, or community-based case manager are also required to submit critical incident reports to the BLTC care, via the IMPA, any time a restrictive intervention is utilized.

Providers are required to maintain a system for the review, approval and implementation of ethical, safe, humane and efficient behavioral intervention procedures, that inform the member and his/her legal guardian

of the behavioral intervention policy and procedures at the time of entry into a facility and as changes occur. Non-aversive methods of intervention must be designed and utilized as the option of first use, prior to design or implementation of any behavioral intervention containing aversive techniques.

Behavioral intervention procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a nonaversive program. Behavioral intervention procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. Corporal punishment and verbal or physical abuse are prohibited. Restrictions may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:

- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of restrictions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Restrictions and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. A person's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (i) the supervisor's ability to implement the procedure has been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an member's behaviors.

Restrictions and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter a member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager, health home coordinator, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements:

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the member's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the member and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the Behavioral Intervention Program must include:

- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the

court.

- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as, and includes, the following components:
  - (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;
  - (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;
  - (iii) description of the conditions that precede the behavior in question;
  - (iv) description of what appears to reinforce and maintain the behavior; and
  - (v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Restrictions must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All restrictions are explained to the member and their legal representative and agreed upon ahead of time. Unauthorized use of restrictions would be detected via interviews with the member, their family and staff and case manager, health home coordinator, or community-based case manager; through review of critical incident reports by DHS and member's case manager, health home coordinator, or community-based case manager on a daily basis; DHS and case manager, health home coordinator, or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints).

Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the DHS policy for each type of agency identified restriction is observed and member rights are safeguarded. If it is found that a waiver provider is not observing DHS policy or ensuring a member's rights, adverse action is taken by the IME, which may include sanction, termination, required corrective action, etc.

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

The member's case manager, health home coordinator, or community-based case manager, is responsible to monitor individual plans of care including the use of restrictions and behavioral interventions.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The IME's HCBS QA unit is responsible for overseeing the use of restrictive interventions and ensuring that state safeguards concerning their use are followed. The QA contract monitors all FFS incident reports. In a case where the member has had a restraint or restrictive intervention which is not in their service plan the incident and complaint specialist follows up. Follow up consists of additional information being requested, a corrective action plan, and verification of compliance. FFS and MCO Case managers are also responsible for reviewing incident reports for their members and ensuring restrictive interventions are in alignment with the service plan.

A restrictive intervention is an action or procedure that imposes a restriction of movement, that limits a participant's movement, access to other individuals, locations or activities, or restricts a participant's rights. 441-IAC 77.25(4) describes restrictive interventions as restraints, restrictions and behavioral intervention. Per the description of restrictive interventions noted in the application (G-2-b-i)above, Iowa will need to review its inclusion of restraint as a restrictive intervention.

The first line of responsibility for overseeing the use of restrictive interventions and ensuring safeguards are in place is the member's case manager, integrated health home care coordinator, or community based case manager. The use of restrictive interventions must be assessed as needed and identified in the individual member's service plan. The use of restrictions would also require the development and implementation of a restrictive intervention plan and the plan would be included in the participant's service plan. The member's case manager, integrated health home care coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restrictive interventions would be addressed with the provider of service and corrected as needed.

The State contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restrictions. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether restrictions are appropriately incorporated into the service plan, such that restrictions are only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers, regardless if serving FFS or MCO members, are required to submit major incident reports. Categories within the incident report include inappropriate use of restrictions.

#### FFS

For FFS members, provider reports of restrictive interventions are entered into IMPA, which trigger milestones in ISIS for fee-for-service members. These triggers alert case managers and integrated health home care coordinators, and prompt the IME HCBS Incident Reporting Specialist to conduct a review of the restrictive intervention. If it is found that the restrictive intervention demands further investigation, the issue is passed to the HCBS Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of restrictions, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to the IME Program Integrity Unit for possible sanctions that may apply.

#### MCO

For MCO members, provider reports are entered into the designated MCO critical incident reporting system. In the MCO system and processes, MCO CBCMs are alerted along with the MCO Critical Incident Reporting Specialist to conduct a review of the restrictive intervention. Processes for targeted review, provider corrective actions and PI referral, if warranted, are followed as discussed in the FFS process.

#### IPES INTERVIEWS

The HCBS Quality Assurance Unit is also responsible for conducting IPES interviews for FFS members. The MCOs conduct the same IPES interviews for MCO members. The IPES tool has been expanded based

on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the individual interviewed and service enrollment. IPES interviews are conducted either face-to-face or via telephone at the discretion of the waiver member. All waiver members have the right to decline an interview. The results of these interviews are presented to the state on a quarterly basis.

Finally, the HCBS Unit compiles all data related to incidents associated with the inappropriate use of restrictions, as well as data from periodic and targeted provider reviews. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

MCO Community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restrictive interventions would be addressed with the provider of service and corrected as needed. In addition, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.).

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

**The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

**i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DHS policy regarding seclusion is as follows, and applies to all types of seclusions that may be used by waiver providers, regardless of delivery system (i.e., FFS or MCO) Examples of seclusion include but are not limited to locking a member in a room, locking a member out of an area of their residence, or limiting community time. All incidents of seclusion must be documented in the member's service record and reported to the IME as a critical incident. As a rights limitation, the seclusion procedures must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of seclusion must be documented in a member's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures." All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

- a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
- b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
- c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
- d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
- e. Corporal punishment and verbal or physical abuse are prohibited."

The same standard is used for seclusion as a restrictive intervention. All seclusions must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Seclusion procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

Seclusion may be allowed depending on the provider's agency policy to ensure that there is an accompanying behavioral intervention plan, documentation of each instance, and monitoring of its use. Seclusion can be considered on an individual basis after the interdisciplinary team reviews them, and are entered into the written plan of care with specific time lines. If a member were placed in a closed room, the time frame would need to be determined on an individual basis and spelled out in the service plan. The provider would need to document the use of this seclusion in the member's service file each time it was utilized by staff. The provider would be required to have a written policy approved by DHS on the supervision and monitoring of members placed in a closed room, such as monitoring on a fifteen minute basis to assure the health and welfare of the member.

Seclusion procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:

- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of seclusions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Seclusions and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it

is written. A person's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (
  - i) the supervisor's ability to implement the procedure has been documented by a program staff person;
  - ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and
  - (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Seclusion and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter a member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member service plan and the case manager, health home coordinator, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements.

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the person's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the individual and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:

- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as and includes the following components:
  - (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;
  - (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;
  - (iii) description of the conditions that precede the behavior in question;
  - iv) description of what appears to reinforce and maintain the behavior; and
  - v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Seclusions must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All seclusions are explained to the member and their legal representative and agreed upon ahead of time.

Unauthorized use of seclusion would be detected via interviews with the member, their family and staff and case manager, health home coordinator, or community-based case manager; through review of critical incident reports by DHS and member's case manager, health home coordinator, or community-based case manager on a daily basis; DHS and case manager, health home coordinator, or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints). Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the DHS policy for each type of agency identified seclusion is observed and member rights are safeguarded. If it is found that a waiver provider is not observing DHS policy or ensuring a member's rights, adverse action is taken by the IME, which may include sanction, termination, required corrective action, etc.

The member's case manager, health home coordinator, or community-based case manager, is responsible to monitor individual plans of care including the use of seclusion and behavioral interventions.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The IME's HCBS QA unit is responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed. The QA contract monitors all FFS incident reports. In a case where the member has had a seclusion which is not in their service plan the incident and complaint specialist follows up. Follow up consists of additional information being requested, a corrective action plan, and verification of compliance. FFS and MCO Case managers are also responsible for reviewing incident reports for their members and ensuring uses of seclusions are in alignment with the service plan.

The first line of responsibility for overseeing the use of seclusion and ensuring safeguards are in place is the member's case manager, health home coordinator, or community based case manager. The use of seclusion must be assessed as needed and identified in the individual member's service plan. The use of seclusion would also require the development and implementation of a behavior plan and the plan would be included in the member's service plan. The case manager, health home coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of seclusion would be addressed with the provider of service and corrected as needed.

The State contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with seclusion. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether seclusion is appropriately incorporated into the service plan, such that seclusion is only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of seclusion. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service members that alert case managers, health home coordinators and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of seclusion, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

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

Finally, the Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of seclusion, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of*

*a family member.*

**a. Applicability.** Select one:

**No. This Appendix is not applicable** (*do not complete the remaining items*)

**Yes. This Appendix applies** (*complete the remaining items*)

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Per 441 Iowa Administrative Code 77.46(5), respite providers must meet the following requirements as a condition of providing respite care under the waiver: (1) training on provision of medication according to agency policy and procedure; and (2) the staff member shall not provide any direct service without the oversight of supervisory staff until training is completed.

The case manager, health home coordinator, or community-based case manager, and any provider responsible for medication administration must monitor the documentation of medication administration to ensure adherence to the service plan and provider policies and procedure. The provider agency frequently and routinely monitors as outlined in their policies and procedures, and quality improvement plans. Provider agencies are expected to review medication administration on a daily basis to ensure health and welfare of member as well as perform quality assurance on a timeframe identified by the agency (most often monthly). The case manager, health home coordinator, or community-based case manager also monitor during the annual service plan development. MCO community-based case managers monitor the documentation of medication administration to ensure adherence to the service plan and provider policies and procedures.

Monitoring includes review of the service documentation to ensure that medications have been administered at the designated times and by designated individuals. Further monitoring occurs through the report of major incidents whenever a medication error results in physicians' treatment, mental health intervention, law enforcement intervention, death, or elopement. When a major incident has occurred, follow-up, investigation, and remediation occurs as identified in G.I.d. All medication errors resulting in a major incident report or discovered via complaint are fully investigated. If it is determined that a harmful practice has been detected, the provider agency completes a corrective action plan and may face sanctions depending on severity and negligence of the circumstance.

The Iowa Medicaid program has actively managed Medicaid pharmacy benefits through a Preferred Drug List (PDL) since 2005. A governor appointed medical assistance pharmaceutical and therapeutics (P&T) committee was established for the purpose of developing and providing ongoing review of the PDL. The prior authorization department of the IME MSU utilizes the PDL to review medication management. First line responsibility lies with the prescriber who is contacted by fax or telephone regarding a prescription. Pharmacists review patient profiles for proper diagnosis, dosage strength and length of therapy.

The DHS Member Services Unit has established procedures to monitor Medicaid members' prescribing physicians and pharmacies. Analysis has established risk thresholds for these factors to mitigate possible abuse, harmful drug reactions, and to improve the outcomes of medication regimes for Medicaid members. When it is identified that members exceed the established risk thresholds, the member is placed in lock-in. Lock-in establishes one prescribing physician and one filling pharmacy for each member. The Member Services Unit also conducts statistical analysis of the use of certain drugs and usage patterns. Identification of trends for prescriptions and usage patterns of high risk or addictive medications is presented to DHS on a monthly or quarterly basis.

Second-line monitoring is conducted concerning the use of behavior modifying medications through a variety of mechanisms. First, member education is designed to ensure appropriate utilization (correcting overutilization and underutilization), at a minimum, and to improve adherence. Second, restriction programs, including policies, procedures, and criteria for establishing the need for the lock-in, may also be implemented. Finally, medication therapy management programs are developed to identify and target members who would most benefit, and include coordination between the participant, the pharmacist and the prescriber using various means of communication and education.

The Drug Utilization Review (DUR) Commission is a quality assurance body, which seeks to improve the quality of pharmacy services and ensure rational, cost-effective medication therapy for Medicaid members in Iowa. The commission reviews policy issues and provides suggestions on prospective DUR criteria, prior authorization guidelines, OTC coverage, and plan design issues. The DUR system provides for the evaluation of individual member profiles by a qualified professional group of physicians and pharmacists, with expertise in the clinically appropriate prescribing of covered outpatient drugs, the clinically appropriate dispensing and monitoring of outpatient drugs, drug use review, evaluations and intervention, and medical quality assurance. Members of this group also have the knowledge, ability, and expertise to target and analyze therapeutic appropriateness, inappropriate long-term use of medication, overuse/underuse/abuse/polypharmacy, lack of generic use, drug-drug interactions, drug-disease contraindications, therapeutic duplications, therapeutic benefit issues, and cost-effective

drug strengths and dosage forms. In addition, the IME MSU reviews Medicaid member records to ensure that the member had a diagnosis or rationale documented for each medication taken.

The Department of Inspections and Appeals (DIA) is responsible for Medicaid member's medication regimes for waiver members served in an RCF/ID. All medical regimes are included in the member's record. Medications administered by the facility are recorded on a medical record by the individual who administers medication. All RCF/IDs are licensed facilities and must meet all Department of Inspections Administrative Rules to obtain an annually renewable license. Medical records are reviewed during licensure renewal. Persons administering medication must be a licensed nurse or physician or have successfully completed a department approved medication aide course. If the provider stores, handles, prescribes, dispenses, or administers prescription or over the counter medications the provider is required to develop procedures for the storage, handling, prescribing, dispensing, or administration of medication. For controlled substances, providers must maintain DIA procedures. If the provider has a physician on staff or under contract, the physician must review and document the provider's prescribed medication regime at least annually in accordance with current medical practice. Policies and procedures must be developed in written form by the provider for the dispensing, storage, and recording of all prescription and nonprescription medications administered, monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, including antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics. Policies and procedures are reviewed by the HCBS Specialists for compliance with state and federal regulations. If deficiencies are found, the provider is required to submit a corrective action, and follow-up surveys may be conducted based on the severity of the deficiency.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Second line responsibility is utilized when issues are more complex. Occurrences of high dosage use for certain medications or prescribing drugs for an age group where the drug is not FDA indicated are sent to DHS-IME for review. In some cases edits have been placed in the computer system so the prescriber could not prescribe for age groups not indicated.

Lock-In: Trending and analysis has been conducted by the MSU and “lock-in” strategies have been implemented for members who have, historically, multiple prescribers and pharmacies. Identification of these members allows the Medicaid payment of only one prescribing physician and one pharmacy. This allows for increased monitoring of appropriate medication management and mitigates the risk associated with pharmacological abuses and negative contraindications.

Drug Utilization Review (DUR) Commission: The DUR is a second line monitoring process with oversight by DHS. The DUR system includes a process of provider intervention that promotes quality assurance of care, patient safety, provider education, cost effectiveness and positive provider relations. Letters to providers generated as a result of the professional evaluation process identify concerns about medication regimens and specific patients. At least one Iowa licensed pharmacist is available to reply in writing to questions submitted by providers regarding provider correspondence, to communicate by telephone with providers as necessary and to coordinate face-to-face interventions as determined by the DUR.

The Department of Inspections and Appeals (DIA): This DIA is responsible for oversight of licensed facilities. DIA communicates all findings to DHS and any issues identified during the RCF/ID licensure process, or critical incidents as they arise. The DIA tracks information and provides training as necessary to improve quality. This information is also shared with DHS. Both the DIA and DHS follow-up with identified RCF/IDs to assure that action steps have been made to ensure potential harmful practices do not reoccur.

HCBS Quality Assurance Unit: DHS contracts with the Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with medication management. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether medications are appropriately incorporated into the service plan. If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The IME’s HCBS QA unit is responsible for overseeing the use of (restraints, seclusion, restrictive intervention, medication management) and ensuring that state safeguards concerning their use are followed. The QA contract monitors all FFS incident reports. In a case where the member has had a restraint or restrictive intervention which is not in their service plan the incident and complaint specialist follows up. Follow up consists of additional information being requested, a corrective action plan, and verification of compliance. FFS and MCO Case managers are also responsible for reviewing incident reports for their members and ensuring (restraints, seclusion, restrictive intervention, medication management) are in alignment with the service plan.

With respect to MCO members, community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of medication would be addressed with the provider of service and corrected as needed. In addition, MCOs must maintain documentation of the member’s medication management done by the MCOs clinical staff; monitor the prescribing patterns of network prescribers to improve the quality of care coordination services provided to members through strategies such as: (a) identifying medication utilization that deviates from current clinical practice guidelines; (b) identifying members whose utilization of controlled substances warrants intervention; (c) providing education, support and technical assistance to providers; and (d) monitor the prescribing patterns of psychotropic medication to children, including children in foster care. Finally, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS Quality Assurance and Technical Assistance

Unit, critical incident review, etc.).

All waiver service providers are required to submit major incident reports. Categories within the incident report include medication errors. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service members that alert case managers and health home coordinators, and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding medication management, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of medication, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

#### c. Medication Administration by Waiver Providers

##### i. Provider Administration of Medications. *Select one:*

**Not applicable.** *(do not complete the remaining items)*

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Respite Service providers must have policies and procedures developed for dispensing, storage, and recording all prescription and nonprescription medication administered. 441 Iowa Administrative Code Chapters 77.30(3)(b)(2), 77.33(6) (b)(2), 77.34(5) (b)(2), 77.37(15) (b)(2), 77.39(14) (b)(2), and 77.46(5)(e) state:

“Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing. All medications shall be stored in their original containers, with the accompanying physician’s or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to members and the public. Nonprescription medications shall be labeled with the member’s name. In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.”

Providers are required to have staff trained on medication administration and provide safe oversight of medication administration. The State does not require specific medication administration curriculum to be used. Providers are responsible to assure that staff has the skills needed to administer medications safely. There are no uniform requirements in the Iowa Administrative Code for the provision of medication administration or for the self-administration of medications by Medicaid members.

The Provider Self-Assessment quality improvement process requires providers to have a policy and procedure for the storage and provision of medication. This process requires a more uniform approach for the provider in the requirements for medication management. The Provider Self-Assessment review checklist used by the HCBS Specialist to review providers identifies the following minimum standards that the medication policy will identify:

- The provider’s role in the management and/or administration of medications
- If staff administers medications, the policy will identify the: (1) training provided to staff prior to the administration of medications; (2) method of documenting the administration of medications; (3) storage of medications; (4) the assessment process used to determine the Medicaid member’s role in the administration of medications.

The provider Self-Assessment process also requires providers to have discovery, remediation and improvement processes for medication administration. The information and results of these activities is available to DHS upon request. Currently the self-assessment process is not set forth in the Iowa Administrative Code.

Home Health agencies that provide waiver services must follow Medicare regulations for medication administration and dispensing. All medications must be stored in their original containers with the accompanying physician's or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to Medicaid members and the public. Nonprescription medications shall be labeled with the Medicaid member's name. In the case of medications that are administered on an ongoing long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription. All providers of respite must develop policies that assure that personnel that administer medications have the appropriate skills and that there is oversight by medical personnel.

Provider non-medical waiver staff that administers medications must have oversight of a licensed nurse. If the medication requires, the staff is required to complete a medication management course through a community college.

The requirements for non-medical waiver providers must have in order to administer medications to Medicaid members who cannot self-administer is that the provider must have a written policy in place on what the requirements are for their staff to do this and how. If the medications are psychiatric medications the person would have to have successfully completed a medication aide class. Oversight for a staff member who administers medications that require oversight such as in the case of psychiatric medications would need to follow the requirements as spelled out through the Board of Nursing such as having oversight by a registered nurse. The HCBS Specialists through IME would oversee this policy upon regular reviews of the provider.

State oversight responsibility is described in Appendix H for the monitoring methods that include identification of problems in provider performance and support follow-up remediation actions and quality improvement activities.

**iii. Medication Error Reporting.** *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

*Complete the following three items:*

(a) Specify state agency (or agencies) to which errors are reported:

Providers are required to complete incidents reports for all occurrences meeting the criteria for major and minor incidents and make the incident reports and related documentation available to DHS upon request. Major incidents must be reported to the BLTC via IMPA. Providers must ensure cooperation in providing pertinent information regarding incidents as requested by DHS.

As part of the major incident reporting process described in Appendix G-1, DHS will review and follow-up on all medication errors that lead to a member hospitalization or death. This can include the wrong dosage, the wrong medication delivered, medication delivered at the wrong time, Medicaid delivery not documented, unauthorized administration of medication, or missed dosage. Providers are required to submit all medication errors, whether major or minor, to the member's case manager, health home coordinator, or community-based case manager when they occur. The case manager, health home coordinator, or community-based case manager monitors the errors and makes changes to the member's service plan as needed to assure the health and safety of the member.

The Provider Self-Assessment quality improvement process requires providers to have a policy and procedure regarding medication administration and medication management. The Provider Self-Assessment process also requires that providers have discovery, remediation, and improvement processes for medication administration and medication errors. Specifically, providers are required to have ongoing review of medication management and administration to ensure that medications are managed and administered appropriately. Providers are also required to track and trend all medication errors to assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to DHS upon request and will be reviewed as part of the ongoing Self-Assessment process conducted by the HCBS Specialists. This will include random sampling of providers, incident specific review (complaint and IR follow up) and on-site provider review held every five years. DHS is in the process of promulgating rules to establish the Provider Self-Assessment quality improvement process in the Administrative Code.

Other professionals or family members may report medication error incidents at any time as a complaint. Suspected abuse is reported to the reporting hotline operated by the Department of Human Services.

(b) Specify the types of medication errors that providers are required to *record*:

Providers must track and trend all major and minor incident reports. Per Chapter 441 Iowa Administrative Code 77.25(1), “major incidents” are defined as an occurrence involving a participant during service provision that: (1) results in a physical injury to or by the participant that requires a physician’s treatment or admission to a hospital; (2) results in the death of any person; (3) requires emergency mental health treatment for the participant; (4) requires the intervention of law enforcement; (5) requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; (6) constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or (7) involves a participant’s location being unknown by provider staff who are assigned protective oversight. Service providers, provider staff, DHS TCM, MCO CBCM, health home coordinators, and community-based case managers are required to submit incident reports as they are witnessed or discovered. All major incidents must be reported within 48 hours of witnessing or discovering an incident has occurred, using the IME’s Iowa Medicaid Portal Access (IMPA) System. Suspected abuse may be reported to the statewide abuse reporting hotline operated by DHS.

Per Chapter 441 Iowa Administrative Code 77.25(1), “minor incidents” are defined as an occurrence involving a participant during service provision that is not a major incident and that: (1) results in the application of basic first aid; (2) results in bruising; (3) results in seizure activity; (4) results in injury to self, to others, or to property; or (5) constitutes a prescription medication error. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider’s system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the participant’s file.

Providers are required to record all medication errors, both major and minor, that occur. Providers are required to track and trend all medication errors and assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to DHS upon request and will be reviewed as part of the ongoing Self-Assessment process conducted by the HCBS Specialists.

(c) Specify the types of medication errors that providers must *report* to the state:

Only major incidents of medication errors that affect the health and safety of the member, as defined by the major incident criteria, are required to be reported to the State. All medication errors, both major and minor, are required to be reported to the member’s guardian, case manager, health home coordinator, or community-based case manager.

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Bureau of Long Term Care (BLTC) is responsible for the oversight of waiver providers in the administration of medications to waiver members. Oversight monitoring is completed through IMPA, the provider Self-Assessment process, and monitoring of the member by the member's case manager, health home coordinator, or community-based case manager.

With respect to MCO members, community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of medication would be addressed with the provider of service and corrected as needed. In addition, MCOs must maintain documentation of the member's medication management done by the MCOs clinical staff; monitor the prescribing patterns of network prescribers to improve the quality of care coordination services provided to members through strategies such as: (a) identifying medication utilization that deviates from current clinical practice guidelines; (b) identifying members whose utilization of controlled substances warrants intervention; (c) providing education, support and technical assistance to providers; and (d) monitor the prescribing patterns of psychotropic medication to children, including children in foster care. Finally, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.). All of these processes have been described in detail in this Appendix.

All medication errors are considered either major or minor incidents, as noted in Subsection "iii.b" above. These major incidents are reported to the department and follow the incident reporting follow up protocol of the department.

DHS contracts with the HCBS Quality Assurance Unit to oversee the appropriateness of provider policies and procedures, and service plan components associated with medication management. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether medications are appropriately incorporated into the service plan. If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate medication administration. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service members that alert member case managers and health home coordinators, and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding medication administration, the provider is required to complete a CAP and implement the CAP to 100% compliance. Again, if it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The Unit compiles all data related to incidents reported in IMPA associated with the inappropriate medication administration, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

#### **a. Methods for Discovery: Health and Welfare**

**The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.** (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

**i. Sub-Assurances:**

- a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**HW-a1: The IME will measure the total number and percent of IAC-defined major critical incidents requiring follow-up escalation that were investigated. Numerator = # of critical incidents that received follow-up as required; Denominator = # of critical incidents requiring follow-up escalation**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

**Data collected in the FFS and MCO CIR databases.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:  <input type="text" value="Contracted Entity and MCOs"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**HW-a2: The IME will measure CIs that identify a reportable event of abuse, neglect, exploitation, or unexplained death and were followed upon appropriately. Numerator = # of CIRs that identified a report was made to DHS protective services and/or appropriate follow up was initiated; Denominator = # of CIs that identified a reportable event of abuse, neglect, exploitation, and/or unexplained death**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

**FFS and MCO CIR databases**

<b>Responsible Party for</b>	<b>Frequency of data</b>	<b>Sampling Approach</b>
------------------------------	--------------------------	--------------------------

<b>data collection/generation</b> <i>(check each that applies):</i>	<b>collection/generation</b> <i>(check each that applies):</i>	<i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="Contracted Entity and MCOs"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**HW-a3** The IME will measure the number and percent of members who received information on how to report abuse, neglect, exploitation and unexplained death

**Numerator:** # of members service plans that indicate the members received

information on how to report abuse, neglect, exploitation and unexplained deaths

**Denominator:** Total # of service plans reviewed

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="95% +/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:

		IA.0213 AIDS/HIV (.05%) IA.0242 ID (47%) IA.0299 BI (6%) IA.0345 PD (4%) IA.0819 CMH (4%) IA.4111 HD Waiver (9%) IA.4155 - Elderly Waiver (30%)
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/> MCO and contracted entity	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):

**b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**HW-b1: The IME will identify all unresolved critical incidents which resulted in a targeted review and were completed to resolution. Numerator = # of targeted reviews resulting from an incident which were resolved within 120 days; Denominator = # of critical incidents that resulted in a targeted review.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

**FFS/HCBS Unit and MCO data obtained from CIR databases.**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

Contracted Entity and MCOs		
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**HW-b2** The IME will measure the number and percent of critical incidents where root cause was identified  
**Numerator:** Number and percent of critical incidents where root cause was identified  
**Denominator:** # of Critical Incident Reports

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for</b>	<b>Frequency of data</b>	<b>Sampling Approach</b>
------------------------------	--------------------------	--------------------------

<b>data collection/generation</b> <i>(check each that applies):</i>	<b>collection/generation</b> <i>(check each that applies):</i>	<i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:  <input type="text" value="MCO and contracted entity"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**HW-c1: The IME will measure the total # & % of providers with policies for restrictive measures that are consistent with State and Federal policy and rules, and followed as written. Numerator = # providers reviewed that have policies for restrictive measures that were implemented as written; Denominator = total # of providers reviewed**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

**Provider's policies and procedures. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative</b>

		<b>Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="Contracted Entity"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**d. Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**HW-d1: The IME will measure the number and percent of providers meeting state and federal requirements relative to individual waivers. Numerator = # of Quality Assurance reviews that did not receive a corrective action plan; Denominator = # of provider Quality Assurance Reviews completed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

**All QA reviews that don't result in a corrective action. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="Contracted Entity"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The HCBS Quality Assurance unit and each MCO is responsible for monitoring and analyzing data associated with the major incidents reported for members on waivers. Data is pulled from the data warehouse and from MCO reporting on a regular basis for programmatic trends, individual issues and operational concerns. Reported incidents of abuse, medication error, death, rights restrictions, and restraints are investigated further by the HCBS Incident Reporting Specialist as each report is received. The analysis of this data is presented to the state on a quarterly basis.

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The HCBS Incident Reporting Specialist and each MCO analyzes data for individual and systemic issues. Individual issues require communication with the case manager to document all efforts to remediate risk or concern. If a these efforts are not successful, staff continues efforts to communicate with the case manager, the case manager's supervisor, and protective services when necessary. All remediation efforts of this type are documented in the monthly and quarterly reports.

The HCBS Specialists conducting interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. MCO are responsible for research and follow up to flagged responses. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes to provider policy.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  Contracted Entity and MCOs	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix H: Quality Improvement Strategy (1 of 3)**

---

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may

provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## **Appendix H: Quality Improvement Strategy (2 of 3)**

---

### **H-1: Systems Improvement**

#### **a. System Improvements**

- i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The IME is the single state agency that retains administrative authority of Iowa's HCBS Waivers. Iowa remains highly committed to continually improve the quality of services for all waiver programs. The IME discovered over the course of submitting previous 1915(c) waiver evidence packages that previously developed performance measures were not adequately capturing the activities of the IME. For this reason, state staff developed new performance measures to better capture the quality processes that are already occurring or being developed.

The QIS developed by Iowa consolidates and stratifies performance data across all seven 1915(c) waivers. The HCBS waiver population will be identified based waiver enrollment at a single point in time. A 95% confidence level with a 5% error rate for the total waiver population is calculated. In an effort to ensure each waiver is represented within the sample identified for the reporting year, the specific waiver enrollment will be divided by the total waiver population to identify the percentage the specific waiver contributes to the overall waiver population during that reporting year. The significant sample will be multiplied by the percentage identified for each waiver to identify the number of surveys/reviews that need to be completed for each waiver. This process is completed for each waiver to ensure that the 95% confidence level is met and that each waiver is appropriately sampled.

A common capture date will be used to count enrollment for all waivers.

Iowa will begin consolidated performance data collection April 1, 2020. The first consolidated evidence reports will be for the Physical Disability and Health and Disability Waivers reports due to CMS in January 2021. There are no performance measure unique to the Children's Mental Health Waiver.

IA.0213 - AIDS/HIV Waiver (.05%)

IA.0242 - ID Waiver (47%)

IA.0299 - BI Waiver (6%)

IA.0345 - PD Waiver (4%)

IA.0819 - CMH Waiver (4%)

IA.4111 - HD Waiver (9%)

IA.4155 - Elderly Waiver (30%)

Based on contract oversight and performance measure implementation, the IME holds weekly policy staff and long term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff. Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance committee meets monthly to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. ISIS will only be utilized for fee-for-service participants.

All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas. The QM/QI program must have objectives that are measurable, realistic and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 Subpart E and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program. The State has developed a draft-reporting manual for the MCOs to utilize for many of the managed care contract reporting requirements. The managed care contract also allows for the State to request additional regular and ad hoc reports.

Iowa has acknowledged that improvements are necessary to capture data at a more refined level, specifically individual remediation. While each contracting unit utilizes their own electronic tracking system or OnBase (workflow management), further improvements must be made to ensure that there are not preventable gaps collecting individual remediation. The State acknowledges that this is an important component of the system; however the terrain where intent meets the state budget can be difficult to manage.

The IME supports infrastructure development that ensures choice is provided to all Medicaid members seeking

services and that these services are allocated at the most appropriate level possible. This will increase efficiency as less time is spent on service/funding allocation and more time is spent on care coordination and improvement. A comprehensive system of information and referrals ensures that all individuals are allowed fully informed choices prior to facility placement.

The Medicaid Quality Utilization and Improvement Data System (MQUIDS) is a data entry and retrieval application designed to facilitate the Medical Services contractor’s job functions including level of care determinations, medical service prior authorizations, documentation review and the retention of other pertinent member data . The content is guided by the business and policy requirements of medical review. The medical services reviews frequently involve the documentation of health information on individual members that must be protected

A comprehensive system of information and referrals shall also be developed such that all individuals are allowed fully informed choices prior to facility placement. Many program integrity and ACA initiatives will assist in system improvements. These include improvements to provider screening at enrollment, tighter sanction rules, and more emphasis on sustaining quality practices.

**ii. System Improvement Activities**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Quality Improvement Committee</b>	<b>Annually</b>
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 2px; width: fit-content;">Contracted Entity (Including MCOs)</div>	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**b. System Design Changes**

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The IME has hired a Quality Assurance Manager to oversee the data compilation and remediation activities associated with the revised performance measures. The QA Manager and State policy staff address oversight of design changes and the subsequent monitoring and analysis during the weekly policy and monthly quality assurance meetings. Prior to dramatic system design changes, the State will seek the input of stakeholders and test/pilot changes that are suggested and developed. Informational letters are sent out to all relevant parties prior to implementation with contact information of key staff involved. This workflow is documented in logs and in informational letters found within the DHS computer server for future reference. Stakeholder involvement and informational letters are requested or sent out on a weekly/monthly/ongoing basis as policy engages in the continuous quality improvement cycle.

Unit managers, policy staff and the QA committee continue to meet on a regular basis (weekly or monthly) to monitor performance and work plan activities. The IME Management and QA committees include representatives from the contracted units within the IME as well as State staff. These meetings serve to present and analyze data to determine patterns, trends, concerns, and issues in service delivery of Medicaid services, including by not limited to waiver services. Based on these analyses, recommendations for changes in policy are made to the IME policy staff and bureau chiefs. This information is also used to provide training, technical assistance, corrective action, and other activities. The unit managers and committees monitor training and technical assistance activities to assure consistent implementation statewide. Meeting minutes/work plans track data analysis, recommendations, and prioritizations to map the continuous evaluation and improvement of the system. IME analyzes general system performance through the management of contract performance benchmarks, ISIS reports, and Medicaid Value Management reports and then works with contractors, providers and other agencies regarding specific issues. The QA committee directs workgroups on specific activities of quality improvement and other workgroups are activated as needed.

In addition to developing QM/QI programs that include regular, ongoing assessment of services provided to Medicaid beneficiaries, MCOs must maintain a QM/QI Committee that includes medical, behavioral health, and long-term care staff, and network providers. This committee is responsible for analyzing and evaluating the result of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action, and ensuring appropriate follow-up. This committee is also responsible for reviewing and approving the MCOs' QM/QI program description, annual evaluation, and associated work plan prior to submission to DHS.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The IME reviews the overall QIS no less than annually. Strategies are continually adapted to establish and sustain better performance through improvements in skills, processes, and products. Evaluating and sustaining progress toward system goals is an ongoing, creative process that has to involve all stakeholders in the system.

Improvement requires structures, processes, and a culture that encourage input from members at all levels within the system, sophisticated and thoughtful use of data, open discussions among people with a variety of perspectives, reasonable risk-taking, and a commitment to continuous learning. The QIS is often revisited more often due to the dynamic nature of Medicaid policies and regulations, as well as the changing climate of the member and provider communities.

In accordance with 42 CFR 438 Subpart E, the State will maintain a written strategy for assessing and improving the quality of services offered by MCOs including, but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries. MCOs must comply with the standards established by the State and must provide all information and reporting necessary for the State to carry out its obligations for the State quality strategy. MCOs are contractually required to ensure that the results of each external independent review are available to participating health care providers, members, and potential members of the organization, except that the results may not be made available in a manner that discloses the identity of any individual patient. Further, MCOs must establish stakeholder advisory boards that advise and provide input into: (a) service delivery; (b) quality of care; (c) member rights and responsibilities; (d) resolution of grievances and appeals; (e) operational issues; (f) program monitoring and evaluation; (g) member and provider education; and (h) priority issues identified by members. In accordance with 42 CFR 438 Subpart E, the State will regularly monitor and evaluate the MCOs' compliance with the standards established in the State's quality strategy and the MCOs' QM/QI program. The State is in the process of developing specific processes and timelines to report results to agencies, waiver providers, participants, families, other interested parties and the public. This will include strategies such as leveraging the Medical Assistance Advisory Council (MAAC).

The HCBS Quality Assurance Unit (QAU) completes review of HCBS enrolled providers on a three-five year cycle. During the onsite review HCBS ensures personnel are trained in:

- Abuse reporting
- Incident reporting
- Have current mandatory reporter training
- Individual member support needs
- Rights restrictions
- Provision of member medication

In addition HCBS QAU reviews the centralized incident report file, appeals and grievances, and any allegations of abuse. During the review of service documentation any incident identified in narrative which falls under the Incident description in 77.25(3), is required to have an incident report filed. The agencies tracking and trending of incident reports is also reviewed during the onsite review. Any areas the agency may be out of compliance in results in the requirement of a corrective action plan. HCBS

gives the provider 30 days to submit a time limited corrective action plan which will remediate the deficiency. 45 days after the corrective action plan has been accepted HCBS follows up and requires the agency to submit evidence that the corrective action plan was put into place.

## Appendix H: Quality Improvement Strategy (3 of 3)

### H-2: Use of a Patient Experience of Care/Quality of Life Survey

**a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):**

No

Yes (*Complete item H.2b*)

**b. Specify the type of survey tool the state uses:**

HCBS CAHPS Survey :

NCI Survey :

**NCI AD Survey :****Other** (Please provide a description of the survey tool used):

*The state of Iowa uses the Participant Experience Survey (PES). The PES is an interview tool developed by MEDSTAT under a contract from CMS. Iowa has added a few Iowa specific questions around employment to the PES.*

***Appendix I: Financial Accountability***

---

***I-1: Financial Integrity and Accountability***

***Financial Integrity.*** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*The IME Program Integrity (PI) unit conducts audits on all Medicaid Provider types including HCBS providers. Any suspected fraud is referred to the Department of Inspection and Appeals Medicaid Fraud and Control Unit (MFCU). The PI Unit vendor is contractually required to review a minimum of 60 cases in each quarter across all provider types. Reviewed cases include providers who are outliers on multiple parameters of cost, utilization, quality of care, and/or other metrics. Reviews are also based on referrals and complaints received. Reviews include review of claims data and service documentation to detect such aberrancies as up-coding, unbundling, and billing for services not rendered. This monitoring may involve desk reviews or provider on-site reviews. During a desk review the provider is required to submit records for review. The PI vendor must initiate appropriate action to recover improper payments on the basis of its reviews. They must work with the Core MMIS contractor to accomplish required actions on providers, including requests to recover payment through the use of credit and adjustment procedures.*

*The PI vendor must report findings from all reviews to DHS, including monthly and quarterly written reports detailing information on provider review activity, findings and recoveries. Requests for provider records by the PI unit include Form 470-4479, Documentation Checklist, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d” to document the basis for services or activities provided.*

*Since transitioning to a combined 1915(b)/1915(c) model on 4/1/2016, Iowa had anticipated that the vast majority of HCBS claims are paid through MCOs. But recent data queries have found this assumption to not be valid. At this time, the IME Program Integrity unit only reviews claims submitted through the Fee-For-Service (FFS) system for members who are not enrolled in an MCO. The IME has found that it is more efficient and productive for the PI Unit to use more targeted strategies to identify providers for review, such as using data analysis and algorithms to identify billing aberrancies, as well as referrals and complaints that come from various sources. The PI vendor may conduct on-site reviews, but there is no requirement for a set percentage of reviews to be conducted on-site.*

*Should the State require a provider to perform a self-review, the prescribed methodology for review is determined on a case-by-case basis, and is generally determined based on the nature and scope of the issue identified. The state compares the results of the MCO program integrity efforts to the results achieved in past years. However, MCO operations tend to rely more on prior authorization of services and pre-payment claims editing to control costs, and as such this type of comparison will not be straightforward and may not provide useful information.*

*When the PI vendor identifies an overpayment for FFS claims, a Preliminary Report of Tentative Overpayment (PROTO) letter is sent to the provider. The PROTO letter gives the provider an opportunity to ask for a re-evaluation and they may submit additional documentation at that time. After the re-evaluation is complete, the provider is sent a Findings and Order for Repayment (FOR) letter to notify them of any resulting overpayment. Both the PROTO letter and the FOR letter are reviewed and signed off by state PI staff prior to mailing. The FOR letter also includes appeal rights to inform the provider that they may appeal through the State Fair Hearing process. When overpayments are recovered, claims adjustments are performed which automatically results in the FFP being returned to CMS.*

*The OHCDS Medicaid audit is subject to the same standards and processes as outlined for FFS. The state’s contracted MCOs are also responsible for safeguarding against, and investigating reports of, suspected fraud and abuse. MCOs are required to fully cooperate with the DHS PI Unit by providing data and ongoing communication and collaboration. Per 42 CFR 438.608 and 42 CFR Part 455, MCOs must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The PI Plan must be updated annually and submitted to DHS for review and approval. The MCOs are also required to make referral to IME and the MFCU for any suspected fraudulent activity by a provider. On a monthly basis, the MCO must submit an activity report to DHS, which outlines the MCO’s PI-related activities and findings, progress in meeting goals and objectives, and recoupment totals. Each MCO is also required to meet in person with the IME PI Unit, the IME Managed Care Oversight Bureau, and the MFCU on at least a quarterly basis to coordinate on open cases and review the MCO’s program integrity efforts. Iowa’s MCOs continuously conduct reviews/audits on providers in their networks. The degree to which these include HCBS providers varies over time depending on tips received and leads from data analytics.*

*The IME reviews MCO reports monthly to monitor their fraud and abuse activities. From this information, the IME analyzes and trends the data received. A monthly dashboard is created that captures metrics on number or tips, new audits and investigations, number of fraud referrals, amount of overpayments collected, and cost savings/cost avoidance numbers. These numbers are shared with IME leadership monthly, and with the MCOs during their 1:1 monthly program integrity meeting with the IME. At the end of the fiscal year, current MCO stats are compared to previous years and, results of this analysis is presented to IME leadership and the MCOs.*

*As part of the 2017 EQR process, a focused study was conducted regarding Person Centered Care Planning processes of*

*the MCOs. The EQR vendor will be requesting documentation of person centered care planning (including whether or not services are being provided on an ongoing basis in the amount authorized in the service plan) for a sample of MCO members to verify that MCOs are providing services as authorized by the interdisciplinary team. Iowa will use the results of this focused study as a baseline to develop an ongoing review process to ensure MCOs are complying with the guidelines Iowa has provided for statistically significant samples, as well ensure that services are being provided according to the IDT authorized plan of care.*

*Outside of the EQR process, several monitoring techniques are used by the state to monitor service provision compared to the service plan. 1) IPES surveys are conducted by MCOs and FFS, with data compiled and reviewed by the state. 2) Community Based Case Manager (CBCM) Interdisciplinary Team (IDT) Ride Alongs ensure that agreed upon services are included in the final service plan; if they are not then it is flagged for MCO resolution. 3) HCBS QA unit and state policy review of MCO service plan reductions monitoring project ensures member's services are not reduced without substantiating documentation. 4) Provider onsite file reviews where the QA unit reviews random sample of FFS and MCO Person Centered Planning documentation to ensure the authorized service plan matches the approved service plan.*

*The state trends data from the MCO program integrity monthly reports to identify trends in number of tips received, number of audits/investigations opened and closed number of referrals to MFCU, number and amount of overpayments recovered. . A monthly dashboard is created that captures metrics on number of tips, new audits and investigations, number of fraud referrals, amount of overpayments collected, and cost savings/cost avoidance numbers. These numbers are shared with IME leadership monthly, and with the MCOs during their 1:1 monthly meeting with the IME. At the end of the fiscal year, current MCO stats are compared to previous years, results of this analysis is presented to IME leadership and the MCOs.*

*MCOs must also coordinate all PI efforts with IME and Iowa's MFCU. MCOs must have in place a method to verify whether services reimbursed were actually furnished to members as billed by providers, and must comply with 42 CFR Part 455 by suspending payments to a provider after DHS determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual/entity unless otherwise directed by DHS or law enforcement. MCOs shall comply with all requirements for provider disenrollment and termination as required by 42 CFR §455.*

*As part of the state's managed care oversight activities and incompliance with 42 CFR chapter 455, the state assures the following:*

- All MCOs conduct their oversight activities in coordination with the IME-PI Unit and Iowa's MFCU.*
- MCOs verifies that services were actually furnished to the members for which services was reimbursed by issuance of an Explanation of Benefits (EOBs), any discrepancies identified will prompt additional review by the MCOs.*
- MCOs suspend payments to providers whom DHS has issued a credible allegation of fraud suspension, unless otherwise directed by DHS or law enforcement.*
- MCOs complies with all requirements for disenrollment and termination.*

*The Auditor of the State has the responsibility to conduct periodic independent audit of the waiver under the provisions of the Single Audit Act. State auditor performs an audit of the Medicaid waivers every year, and looks at various payment types, provider agreements, eligibility, proper payment, etc. The audit is performed based upon randomly selected members across all waivers.*

*All HCBS cost reports will be subject to desk review audit and, if necessary, a field audit. However, the Waiver does not require the providers to secure an independent audit of their financial statements.*

## **Appendix I: Financial Accountability**

### **Quality Improvement: Financial Accountability**

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

#### **a. Methods for Discovery: Financial Accountability Assurance:**

*The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

##### **i. Sub-Assurances:**

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**  
 (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**FA-a1: The IME will determine the number and percent of FFS reviewed claims supported by provider documentation. Numerator = # of reviewed paid claims where documents supports the units of service; Denominator = # of reviewed paid claims**

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

**Program Integrity reviews claims and evaluates whether there was supporting documentation to validate the claim.**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95% +/- 5%</div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">Contracted entity</div>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i>

		<p>IA.0213 AIDS/HIV (.05%) IA.0242 ID (47%) IA.0299 BI (6%) IA.0345 PD (4%) IA.0819 CMH (4%) IA.4111 HD Waiver (9%) IA.4155 - Elderly Waiver (30%)</p>
	<p><b>Continuously and Ongoing</b></p>	<p><b>Other</b> Specify:</p> <p>Reviewed monthly by pulling a sample of claims from the two most utilized codes per waiver the 1st qtr., remaining qtrs. will include claims from other codes in the waiver, ranked by utilization.</p>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**FA-a2: The IME will determine the number of clean claims that are paid by the managed care organizations within the timeframes specified in the contract. Numerator = # of clean claims that are paid by the managed care organization within the timeframes specified in the contract; Denominator = # of Managed Care provider claims.**

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

**Adjudicated Claims Summary, Claims Aging Summary, and Claims Lag Report.**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/> Contracted entity and MCOs	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**FA-b1: The IME will measure the number and percent of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for waiver services provided. Numerator = # of reviewed claims paid using IME-approved rate methodologies; Denominator = # of reviewed paid claims.**

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

**The DW Unit query pulls paid claims data for all seven of the HCBS waivers.**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="Contracted Entity"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**FA-b2: The IME will measure the number of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology.**

**Numerator: # of Capitation payments made to the MCOs at the approved rates through the CMS certified MMIS. Denominator: # of capitation payments made through the CMS certified MMIS.**

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

**MMIS**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text" value="contracted entity"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Program Integrity unit samples provider claims each quarter for quality. These claims are cross-walked with service documentation to determine the percentage of error associated with coding and documentation. This data is reported on a quarterly basis.

MCO claims data is compared to the contractual obligations for MCO timeliness of clean claim payments. Data is provided to the HCBS staff as well as to the Bureau of Managed Care.

MCO contractual definition of a clean claim: A claim that has no defect or impropriety (including any lack of required substantiating Documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments; require screening of all claims, referral to MFCU, or provider suspension.

The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a quarterly basis.

If during the review of capitation payments the IME determines that a capitation was made in error, that claim is adjusted to create a corrected payment.

ii. Remediation Data Aggregation

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design

*methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.*

**No**

**Yes**

*Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.*

## ***Appendix I: Financial Accountability***

---

### ***I-2: Rates, Billing and Claims (1 of 3)***

**a. Rate Determination Methods.** *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

*The IME Provider Cost Audit and Rate Setting Unit recommends to DHS proposed rates for all fee-schedules when not already identified by Medicare or other contracted rates (e.g., counties, AAAs, etc.) honored by Iowa Medicaid.*

*Environmental modifications and adaptive devices, most respite services, and in-home family therapy services are reimbursed by Fee Schedules. Fee schedules are fees for the various procedures involved that are determined by DHS with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources involved in each procedure. Individual adjustments may be made periodically to correct an inequity or to add new procedures or eliminate or modify others.*

*For Environmental Modification, the fee schedule is actually the upper rate/life time maximum available for the service. The state uses a combination of provider bids and internet searches to determine the cost of the requested item(s) unique to the individual member. Rate could be based upon wholesale costs, or an actual acquisition cost of the product to the provider, or product costs included as part of the fee schedule.*

*Respite provided by home health agencies are based on a Medicare Low Utilization Payment Adjustment (LUPA) rates with state geographic wage adjustments less a budget-neutrality factor maintain Medical Assistance expenditures within the amounts appropriated by the Iowa General Assembly.*

*Family and Community Supports services are based on a retrospectively limited prospective rate configured by the IME's audit and rate setting unit in coordination with the provider. With retrospectively limited prospective rates, providers are reimbursed on the basis of a rate for a unit of service calculated prospectively based on projected or historical costs of operation, subject to the maximums listed in the Iowa Administrative Code and to retrospective adjustment based on actual, current costs of operation so as not to exceed reasonable and proper costs by more than 4.5 percent. The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the providers reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs. The prospective rates paid to established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation. The prospective rates paid to both new and established providers are subject to the maximums listed in the Iowa Administrative Code and to retrospective adjustment based on the providers actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.*

*For the Family and Community Supports service, upon finalization of a previous year's cost report the state calculates the amount of the overpayment (if applicable). When overpayments determined for any waiver program, the provider is notified in writing of the overpayment determination. The provider either submits a refund check to the IME or the overpayment is set as a credit balance within the MMIS. Future claim payments are then used to reduce and eliminate the credit balance. The overpayments are recorded and reported to the state data warehouse using an end-of-month A/R reporting process. Any overpayments determined during a particular month are reported for that month. Any recoveries of these overpayments are similarly recorded and reported to the state data warehouse using the same end-of-month A/R process and for the month in which the recoveries were made. The dates on which the respective overpayments occurred and the recoveries made are part of this month-end A/R reporting. Bureau of Fiscal Management staff then extracts this reporting from the data warehouse to construct the CMS-64 report, the official accounting report submitted by the Department to CMS (the state's claiming mechanism for FFP). The CMS-64 report shows CMS what Iowa's net expenditures are for the quarter and is used to determine a final claim of federal funds. The federal-dollar share of any overpayments not recovered within 12 months of the payment itself must be returned to CMS and this is accomplished through the CMS-64 report as well.*

*441 Iowa Administrative Code 79.1 sets forth the principles governing reimbursement of providers of medical and health services. Specifically, "[t]he basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member. Reimbursement types are described at 441 Iowa Administrative Code 79.1(1) (<https://www.legis.iowa.gov/docs/ACO/chapter/441.79.pdf>).*

*Payment levels for fee schedule providers of service will be increased or decreased upon direction of the Iowa Legislature through Medicaid appropriations. There is no set cycle for the Legislature to increase or decrease HCBS provider rates. The provider rates are established in Iowa's Administrative Rules. The legislature can direct IME to increase or decreased provider rates through a legislative mandate. If so, then IME changes the Iowa Administrative Rules accordingly. All provider rates are part of Iowa Administrative Code and are subject to public comment any time there is change. Rate determination methods are set forth in Iowa Administrative Code and subject to the State's Administrative Procedures Act, which requires a minimum twenty-day public comment period. A public hearing by the state agency to take comments is not required unless at least twenty-five persons demand a hearing, though Agency's often schedule a public hearing regardless of the number of comments received. The state agency may revise a rule in response to comments received but is not required to do so. This information is on the website as well as distributed to stakeholders when there is a change. At the time of service plan development, the case managers share with the members the rates of the providers, and the member can choose a provider based on their rates. When a service is authorized in an member's comprehensive services plan, the providers of services receive a Notice of Decision (NOD), which indicates the member's name, provider's name, service to be provided, the dates of service to be provided, units of service authorized, and reimbursement rate for the service.*

*Iowa does allow and anticipate for variability in rates for the same waiver service provided by different providers. For those services where the rate is determined by the provider's cost report, each provider will have a unique rate based upon that provider's cost report. For services paid by a fee schedule, each provider can choose their own rate not to exceed the upper limit of that service as designated in the Iowa Administrative Code. The chosen rate must be based upon cost of service provision.*

*In accordance with 1902(a)(30)(A) of the Act: A change to the rate for any service is done at the direction of the Iowa legislature. This year (2018) the legislature has directed the state to review all current Medicaid fee schedules and submit a report to the governor and legislature regarding how the current rates compare to the Medicare fee schedule or other appropriate reimbursement methodologies for specific services. The report will include a plan for phased-in implementation of any changes.*

*MCO capitation rate development methodologies are described in the §1915(b) waiver and associated materials.*

- b. Flow of Billings.** *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

*For fee-for-service members, providers shall submit claims on a monthly basis for waiver services provided to each member served by the provider agency. Providers may submit manual or electronic claim forms. Electronic claims must utilize a HIPAA compliant software, PC-ACE Pro 32, and shall be processed by the IME Provider Services Unit. Manual claims shall be directed to the Iowa Medicaid Enterprise (IME)/Provider Services Unit.*

*Providers shall submit a claim form that accurately reflects the following: (1) the provider's approved NPI provider number; (2) the appropriate waiver procedure code(s) that correspond to the waiver services authorized in the ISIS service plan; and (3) the appropriate waiver service unit(s) and fee that corresponds to the ISIS service plan.*

*The IME issues provider payments weekly on each Monday of the month. The MMIS system edits insure that payment will not be made for services that are not included in an approved ISIS service plan. Any change to ISIS data generates a new authorization milestones for the case manager or health home care coordinator. The ISIS process culminates in a final ISIS milestone that verifies an approved service plan has been entered into ISIS. ISIS data is updated daily into MMIS.*

*For MCO members, providers bill the managed care entity with whom a member is enrolled in accordance with the terms of the provider's contract with the MCO. Providers may not bill Medicaid directly for services provided to MCO members.*

## **Appendix I: Financial Accountability**

### **I-2: Rates, Billing and Claims (2 of 3)**

- c. Certifying Public Expenditures (select one):**

*No. state or local government agencies do not certify expenditures for waiver services.*

*Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.*

**Select at least one:**

***Certified Public Expenditures (CPE) of State Public Agencies.***

*Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)*

***Certified Public Expenditures (CPE) of Local Government Agencies.***

*Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)*

## ***Appendix I: Financial Accountability***

### ***I-2: Rates, Billing and Claims (3 of 3)***

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

*The MMIS system edits to make sure that claim payments are made only when a member is eligible for waiver payments and when the services are included in the service plan. A member is eligible for a Medicaid Waiver payment on the date of service as verified in ISIS. The billing validation method includes the date the service was provided, time of service provision, and name of actual provider providing the service.*

*Several entities monitor the validity of claim payments: (1) case manager, or health home coordinator ensures that the services were provided by reviewing paid claims information made available to them for each of their members through ISIS; (2) the Iowa Department of Human Services Bureau of Purchased Services performs financial audits of providers to ensure that the services were provided; (3) the IME Program Integrity Unit performs a variety of reviews by either random sample or outlier algorithms.*

*The reviews mentioned in this section are done to confirm that the member was authorized to receive the services, that the provider was a Medicaid enrolled provider, and that provider documentation exists to substantiate the service provision. A provider cannot be paid for a service unless that provider has met all of the provider qualifications to become enrolled with Medicaid. The HCBS QA unit performs routine certification of HCBS providers as discussed in earlier sections of this renewal. In addition, several IPES questions ask members about whether they are using their services and whether staff is spending authorized time with the member.*

*The MMIS system includes system edits to ensure that prior to issuing a capitation payment to an MCO the member is eligible for the waiver program and is enrolled with the MCO. MCOs must implement system edits to ensure that claim payments are made only when the member is eligible for waiver payments on the date of service. The MCOs are required to develop and maintain an electronic community-based case management system that captures and tracks service delivery against authorized services and providers.*

*The State monitors MCO compliance and system capability through pre-implementation readiness reviews and ongoing monitoring such as a review of sampled payments to ensure that services were provided and were included in the member's approved plan of care. The MCOs are also responsible for program integrity functions with DHS review and oversight. The state regularly monitors provider payments through samples determined through a provider escalated process. The frequency and sample is fluid but the methodology is to look at the actual reimbursement compared to the contracted rate for that date of service. Additionally, the encounter data workgroup conducts ongoing quality assurance to monitor the reasonableness of data elements, including units and dollars paid. The legislature has also mandated that the state contract with an external entity to conduct an audit of LTSS small dollar claims paid during one quarter of 2018. Any instances of variances in what is expected to be the reimbursed rate are communicated to the MCO and may be subject to contractual remedies.*

*When inappropriate billings are discovered (i.e.: overpayments determined) the provider is notified in writing of the overpayment determination. The provider either submits a refund check to the IME or the overpayment is set as a credit balance within the MMIS. Future claim payments are then used to reduce and eliminate the credit balance.*

*Meanwhile, the overpayments are recorded and reported to the state data warehouse using an end-of-month A/R reporting process. Any overpayments determined during a particular month are reported for that month. Any recoveries of these overpayments are similarly recorded and reported to the state data warehouse using the same end-of-month A/R process and for the month in which the recoveries were made. The dates on which the respective overpayments occurred and the recoveries made are part of this month-end A/R reporting. Bureau of Fiscal Management staff then extracts this reporting from the data warehouse to construct the CMS-64 report, the official accounting report submitted by the Department to CMS (the state's claiming mechanism for FFP). The CMS-64 report shows CMS what Iowa's net expenditures are for the quarter and is used to determine a final claim of federal funds. The federal-dollar share of any overpayments not recovered within 12 months of the payment itself must be returned to CMS and this is accomplished through the CMS-64 report as well.*

- e. Billing and Claims Record Maintenance Requirement.** *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

## **Appendix I: Financial Accountability**

### **I-3: Payment (1 of 7)**

**a. Method of payments -- MMIS (select one):**

**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

**Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services for fee-for-service enrollees are made by DHS through the MMIS

**Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

**Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

n/a

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

**No. The state does not make supplemental or enhanced payments for waiver services.**

**Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to state or Local Government Providers.** Specify whether state or local government providers receive payment for the provision of waiver services.

**No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.**

**Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.**

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The two State Resource Centers (Woodward Resource Center and Glenwood Resource Center) are the only two state agencies that provide community based services on the CMH waiver. They can provide respite and family and community support services.

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

*The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.*

*The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.*

*The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.*

Describe the recoupment process:

## Appendix I: Financial Accountability

---

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

*For fee-for-service members, providers receive and retain 100% of the amount claimed to CMS for waiver services. The payment to capitated MCOs is reduced by a performance withhold amount as outlined in the contracts between DHS and the MCOs. The MCOs are eligible to receive some or all of the withheld funds based on the MCO's performance in the areas outlined in the contract between DHS and the MCOs.*

## Appendix I: Financial Accountability

---

### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** Select one:

**No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** Select one:

**No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

Enrolled Medicaid providers can choose to subcontract to non-enrolled providers for the provision of Environmental Modifications and Adaptive Devices. The authorization for the service and the Medicaid payment for the authorized service is made to the enrolled Medicaid provider that would then forward payment to the subcontractor in accordance with their contract.

Any subcontractor who is qualified to enroll with Iowa Medicaid is encouraged to do so. No provider is denied Medicaid enrollment for those services that they are qualified to provide. Waiver providers are not required to contract with an OHCDS in order to furnish services to members.

When the case manager, health home coordinator, or community-based case manager has assessed the need for any waiver service, the member is offered the full choice of available providers. The member has the right to choose from the available providers; the list of providers is available through the case manager, health home coordinator or community-based case manager, and is also available through the IME and MCO websites. In accordance with the Iowa Administrative Code, all subcontractors must meet the same criteria guidelines as enrolled providers and the contracting enrolled provider must confirm that all criteria is met.

Environmental modifications and adaptive devices, are reimbursed by Fee Schedules. For Environmental Modification, the fee schedule is actually the upper rate/life time maximum available for the service. The state uses a combination of provider bids and internet searches to determine the cost of the requested item(s) unique to the individual member. Rate could be based upon wholesale costs, or an actual acquisition cost of the product to the provider, or product costs included as part of the fee schedule. Payments made through an OHCD arrangement must adhere to the fee schedules applicable for the provided service.

A provider must enroll with Medicaid prior to being eligible to enroll with a managed care organization. They are not required to contract with a MCO as this is a provider/MCO contractual arrangement. However, Medicaid will notify the MCO of all providers eligible to provide services.

Each MCO has different systems that maintains authorized service plans. Many of the services are prior authorized and claims are adjudicated against the authorizations.

### **iii. Contracts with MCOs, PIHPs or PAHPs.**

**The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

**The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the

*geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

*In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

## ***Appendix I: Financial Accountability***

### ***I-4: Non-Federal Matching Funds (1 of 3)***

***a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:***

***Appropriation of State Tax Revenues to the State Medicaid agency***

***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

*If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

***Other State Level Source(s) of Funds.***

*Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (2 of 3)**

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

*Not Applicable.* There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

Check each that applies:

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (3 of 3)**

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

*None of the specified sources of funds contribute to the non-federal share of computable waiver costs*

**The following source(s) are used**

Check each that applies:

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

**Appendix I: Financial Accountability****I-5: Exclusion of Medicaid Payment for Room and Board****a. Services Furnished in Residential Settings. Select one:**

**No services under this waiver are furnished in residential settings other than the private residence of the individual.**

**As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:**

The only CMH service that may be provided in a residential setting is Respite. The provider manuals contain instructions for providers to follow when providing financial information to determine rates. It states that room and board cannot be included in the cost of providing services. Most respite payments are based upon fee schedules detailed in the Iowa Administrative Code. That fee schedule has no allowance for room and board charges. Respite provided by a home health agency is limited to the established Medicare rate.

The exclusion of room and board from reimbursement is ensured by the Provider Cost Audit Unit. When providers submit cost report documentation and rate setting changes, the Provider Cost Audit Unit accounts for all line items and requests justification for all allocated costs (administrative and other). If it is determined that a provider has attempted to include room and board expenses in cost audits or rate setting documentation, the provider is instructed to make the adjustment and further investigation is conducted to determine if previous reimbursement needs to be recouped by the Iowa Medicaid Enterprise.

All providers of waiver services are subject to a billing audit completed by the Department of Human Services Bureau of Purchased services.

Any payment from an MCO to residential settings is made explicitly for the provision of services as defined by this waiver and excludes room and board. As part of the ongoing monitoring process of MCOs, the State will ensure that payments to residential settings are based solely on service costs.

**Appendix I: Financial Accountability****I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver****Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:**

**No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

**Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

**a. Co-Payment Requirements.** Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

**No.** The state does not impose a co-payment or similar charge upon participants for waiver services.

**Yes.** The state imposes a co-payment or similar charge upon participants for one or more waiver services.

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

**Charges Associated with the Provision of Waiver Services** (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

*Nominal deductible*

*Coinsurance*

*Co-Payment*

*Other charge*

Specify:

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)**

**b. Other State Requirement for Cost Sharing.** Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

**No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

**Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

**Appendix J: Cost Neutrality Demonstration**

**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Hospital**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	9133.30	16730.00	25863.30	9606.00	37948.00	47554.00	21690.70
2	9310.03	17065.00	26375.03	9798.00	38707.00	48505.00	22129.97
3	9501.06	17406.00	26907.06	9994.00	39481.00	49475.00	22567.94
4	9680.85	17754.00	27434.85	10194.00	40271.00	50465.00	23030.15
5	9878.67	18109.00	27987.67	10398.00	41076.00	51474.00	23486.33

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (1 of 9)**

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Hospital	
Year 1	1570		1570
Year 2	1601		1601

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Hospital	
Year 3	1633		1633
Year 4	1666		1666
Year 5	1699		1699

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (2 of 9)**

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) is expected to remain the same throughout the five years of the waiver. The ALOS days were based on 372 reports that incorporated historical ALOS dated back to 07/01/13 and actuarial assumptions from the State's actuary.

The CMS 372 reports used to develop and report ALOS is July 1, 2013 - June 30, 2016.

Unduplicated participants were trended based on assumptions provided by the State's actuary. Lapse rates were included in the assumption calculations provided by the actuary.

Total unduplicated number participants were trended at 2% annually over the five years of the waiver. Unduplicated participants were based on the assumptions provided by the actuary and historical trends.

Limitation on the Number of Participants Served at any Point in Time were projected at 2% growth each year based on historical growth and average monthly costs per member on the waiver.

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (3 of 9)**

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D is impacted by the transition from a fee-for-service program to a managed care capitation rate program. In the prior waiver period, Factor D was adjusted due to the transition to managed care. In this submission, the post-managed care values were increased by 2% each waiver year. The number of unduplicated participants reflects the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.

The 2% increase is trended based on the assumptions provided by the actuary and historical trends based on 372 submissions dating back to 7/1/13.

**ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

*Factor D' is impacted by the transition from a fee-for-service program to a managed care capitation rate program. In the prior waiver period, Factor D' was adjusted due to the transition to managed care. In this submission, the post-managed care values were increased by 2% each waiver year. The number of unduplicated participants reflects the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.*

*Factor D' projections were based on assumptions provided by the State's actuary.*

*The 2% increase is trended based on the assumptions provided by the actuary and historical trends.*

**iii. Factor G Derivation.** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*The Factor G derivation is based on MSIS reports through June 30, 2016. Factor G projections were increased by 2% per year based on historical increases and on assumptions provided by the State's actuary.*

**iv. Factor G' Derivation.** *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*Based on MSIS reports through June 30, 2016. Factor G' projections were increased by 2% per year based on historical data and on assumptions provided by the State's actuary. The CMS 372 reports the State files annually are based on MMIS reports.*

*The change in the number of lives does not have any influence over the calculation of Factor G and/of Factor G'. These are established from historical data and have been trended at a 2% annual increase from the prior 1915(c) waiver filing. The percentage increase for Factor G' is derived from historical Iowa Medicaid cost trends.*

*The main expense included in Factor G' not seen in Factor D' is the inpatient expenses provided by Psychiatric Medical Institutions for Children. Due to the PMIC expenses, Factor G' is actually higher than Factor D'.*

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (4 of 9)**

**Component management for waiver services.** *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Family and Community Support service	
Respite	
Environmental modifications and adaptive devices,	
In-home family therapy	

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (5 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

**Waiver Year: Year 1**

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Family and Community Support service Total:</b>							2195873.15
Family and Community Support Service	<input type="checkbox"/>	15 minutes	1117	179.04	10.92	2183865.47	
Therapeutic Resources	<input type="checkbox"/>	per unit	236	3.00	16.96	12007.68	
<b>Respite Total:</b>							6661097.28
ICF/MR	<input type="checkbox"/>	15 minutes	5	576.00	4.26	12268.80	
Child Care Center	<input type="checkbox"/>	15 minutes	46	2200.00	4.10	414920.00	
Home Care Agency & Non-Facility, Basic Individual	<input type="checkbox"/>	15 minutes	917	768.00	4.54	3197322.24	
Home Care Agency & Non-Facility, Group	<input type="checkbox"/>	15 minutes	626	1312.00	3.50	2874592.00	
HHA Basic Individual	<input type="checkbox"/>	15 minutes	24	1068.00	6.32	161994.24	
<b>Environmental modifications and adaptive devices, Total:</b>							122415.66
Environmental modifications and adaptive devices,	<input type="checkbox"/>	Per unit	54	1.46	1552.71	122415.66	
<b>In-home family therapy Total:</b>							5359896.96
In-home family therapy	<input type="checkbox"/>	15 minutes	1406	132.00	28.88	5359896.96	
<b>GRAND TOTAL:</b>							14339283.04
Total: Services included in capitation:							14339283.04
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1570
Factor D (Divide total by number of participants):							9133.30
Services included in capitation:							9133.30
Services not included in capitation:							
Average Length of Stay on the Waiver:							<input type="text" value="293"/>

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (6 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Family and Community Support service Total:</b>							2263857.12
Family and Community Support Service	<input type="checkbox"/>	15 minutes	1139	179.04	11.04	2251349.22	
Therapeutic Resources	<input type="checkbox"/>	per unit	241	3.00	17.30	12507.90	
<b>Respite Total:</b>							6937895.92
ICF/MR	<input type="checkbox"/>	15 minutes	5	576.00	4.35	12528.00	
Child Care Center	<input type="checkbox"/>	15 minutes	47	2200.00	4.19	433246.00	
Home Care Agency & Non-Facility, Basic Individual	<input type="checkbox"/>	15 minutes	935	768.00	4.63	3324710.40	
Home Care Agency & Non-Facility, Group	<input type="checkbox"/>	15 minutes	641	1312.00	3.57	3002341.44	
HHA Basic Individual	<input type="checkbox"/>	15 minutes	24	1068.00	6.44	165070.08	
<b>Environmental modifications and adaptive devices, Total:</b>							127176.73
Environmental modifications and adaptive devices,	<input type="checkbox"/>	Per unit	55	1.46	1583.77	127176.73	
<b>In-home family therapy Total:</b>							5576424.48
In-home family therapy	<input type="checkbox"/>	15 minutes	1434	132.00	29.46	5576424.48	
<b>GRAND TOTAL:</b>							14905354.25
Total: Services included in capitation:							14905354.25
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1601
Factor D (Divide total by number of participants):							9310.03
Services included in capitation:							9310.03
Services not included in capitation:							
Average Length of Stay on the Waiver:						<input type="text" value=""/>	293

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (7 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Family and Community Support service Total:</b>							2355606.54
Family and Community Support Service	<input type="checkbox"/>	15 minutes	1162	179.04	11.26	2342580.84	
Therapeutic Resources	<input type="checkbox"/>	per unit	246	3.00	17.65	13025.70	
<b>Respite Total:</b>							7224416.44
ICF/MR	<input type="checkbox"/>	15 minutes	5	576.00	4.44	12787.20	
Child Care Center	<input type="checkbox"/>	15 minutes	48	2200.00	4.27	450912.00	
Home Care Agency & Non-Facility, Basic Individual	<input type="checkbox"/>	15 minutes	954	768.00	4.72	3458211.84	
Home Care Agency & Non-Facility, Group	<input type="checkbox"/>	15 minutes	653	1312.00	3.65	3127086.40	
HHA Basic Individual	<input type="checkbox"/>	15 minutes	25	1068.00	6.57	175419.00	
<b>Environmental modifications and adaptive devices, Total:</b>							132078.37
Environmental modifications and adaptive devices,	<input type="checkbox"/>	Per unit	56	1.46	1615.44	132078.37	
<b>In-home family therapy Total:</b>							5803135.80
In-home family therapy	<input type="checkbox"/>	15 minutes	1463	132.00	30.05	5803135.80	
<b>GRAND TOTAL:</b>							15515237.16
Total: Services included in capitation:							15515237.16
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1633
Factor D (Divide total by number of participants):							9501.06
Services included in capitation:							9501.06
Services not included in capitation:							
Average Length of Stay on the Waiver:							<input type="text" value="293"/>

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (8 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Family and Community Support service Total:</b>							2449124.35
Family and Community Support Service	<input type="checkbox"/>	15 minutes	1185	179.04	11.48	2435624.35	
Therapeutic Resources	<input type="checkbox"/>	per unit	250	3.00	18.00	13500.00	
<b>Respite Total:</b>							7505712.48
ICF/MR	<input type="checkbox"/>	15 minutes	5	576.00	4.53	13046.40	
Child Care Center	<input type="checkbox"/>	15 minutes	49	2200.00	4.35	468930.00	
Home Care Agency & Non-Facility, Basic Individual	<input type="checkbox"/>	15 minutes	973	768.00	4.81	3594339.84	
Home Care Agency & Non-Facility, Group	<input type="checkbox"/>	15 minutes	666	1312.00	3.72	3250506.24	
HHA Basic Individual	<input type="checkbox"/>	15 minutes	25	1068.00	6.70	178890.00	
<b>Environmental modifications and adaptive devices, Total:</b>							137125.76
Environmental modifications and adaptive devices,	<input type="checkbox"/>	Per unit	57	1.46	1647.75	137125.76	
<b>In-home family therapy Total:</b>							6036333.60
In-home family therapy	<input type="checkbox"/>	15 minutes	1492	132.00	30.65	6036333.60	
<b>GRAND TOTAL:</b>							16128296.19
Total: Services included in capitation:							16114796.19
Total: Services not included in capitation:							13500.00
Total Estimated Unduplicated Participants:							1666
Factor D (Divide total by number of participants):							9680.85
Services included in capitation:							9672.75
Services not included in capitation:							8.00
Average Length of Stay on the Waiver:							<input type="text" value="293"/>

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (9 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Family and Community Support service Total:</b>							2548784.51
Family and Community Support Service		15 minutes	1209	179.04	11.71	2534739.11	
Therapeutic Resources		per unit	255	3.00	18.36	14045.40	
<b>Respite Total:</b>							7817408.96
ICF/MR		15 minutes	5	576.00	4.62	13305.60	
Child Care Center		15 minutes	50	2200.00	4.44	488400.00	
Home Care Agency & Non-Facility, Basic Individual		15 minutes	993	768.00	4.91	3744483.84	
Home Care Agency & Non-Facility, Group		15 minutes	680	1312.00	3.79	3381286.40	
HHA Basic Individual		15 minutes	26	1068.00	6.84	189933.12	
<b>Environmental modifications and adaptive devices, Total:</b>							137414.85
Environmental modifications and adaptive devices,		Per unit	56	1.46	1680.71	137414.85	
<b>In-home family therapy Total:</b>							6280259.04
In-home family therapy		15 minutes	1522	132.00	31.26	6280259.04	
<b>GRAND TOTAL:</b>							16783867.36
Total: Services included in capitation:							16783867.36
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1699
Factor D (Divide total by number of participants):							9878.67
Services included in capitation:							9878.67
Services not included in capitation:							
Average Length of Stay on the Waiver:							293