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

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

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

HCBS Habilitation Services & Case Management.

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

***Select one*:**

○	**Not applicable**
X	**Applicable**

Check the applicable authority or authorities:

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

X **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Iowa High Quality Healthcare Initiative (Approved 2/23/16, Effective 4/1/16)

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

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

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

		Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
	☐	**A program authorized under §1115 of the Act.** *Specify the program*:

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

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

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

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

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

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

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

1. Individuals are assisted with enrolling in the state plan HCBS Habilitation services through the Iowa Medicaid 's Health Link managed care organizations (MCO), the case manager or integrated health home care coordinator.
2. The Department of Human Services' Income Maintenance Worker determines if the member is eligible for Medicaid and determines the member's income level. The Iowa Medicaid's Medical Services Unit determines if the member meets the needs-based criteria also referred to as the non-financial criteria for enrollment in state plan HCBS. MCOs complete the initial assessment tools and annual reassessment tools for their enrolled membership and provides the information to the Iowa Medicaid Medical Services Unit; the Medical Services Unit evaluates and annually reevaluates the member's eligibility maintaining review and approval authority.

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

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

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

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

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

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

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

Number Served

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

Annual Period	From	To	Projected Number of Participants
Year 1	07/01/2022	06/30/2023	6,975

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

Financial Eligibility

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

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

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

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

Evaluation/Reevaluation of Eligibility

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

×	Directly by the Medicaid agency
	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

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

Individuals performing evaluations must:

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

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

The Iowa Medicaid provides financial eligibility data daily to the MCOs. A member requesting Habilitation services must be Medicaid eligible and have income that does not exceed 150% FPL.

It is the responsibility of the case manager (CM), integrated health home care coordinator (IHHCC), or community-based case manager (CBCM) to assure the assessment is initiated as required to complete the initial needs-based eligibility determination. The initial LOCUS/CALOCUS assessment is completed by the Core Standardized Assessment (CSA) contractor and then sent to the CM/IHHCC/CBCM who uploads the assessment to the Iowa Medicaid MSU. The Iowa Medicaid MSU is responsible for determining the needs-based eligibility based on the completed assessment scoring tool, the comprehensive assessment and social history as well as any other supporting documentation as applicable.

If the member meets the criteria, Habilitation is approved and the MCO, CM/IHHCC/CBCM are notified. The CM/IHHCC/CBCM coordinates the interdisciplinary team meeting to develop the service plan. Once developed, the service plan is submitted to the MCO for Health Link enrollees, or the Medical Services Unit for fee-for-service enrollees for service authorization.

If it is determined that the member will not meet the eligibility criteria for Habilitation based on the results of the LOCUS/ CALOCUS Scoring Tool, the CSA contractor or MCO will complete the interRAI- CMH assessment to determine whether the individual will be eligible for Habilitation based on the results of the previously approved assessment and other supporting documentation.

This process is repeated annually or more often as the member's circumstances or situation dictates to determine continued eligibility and to reauthorize services.

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

MCOs complete the initial assessment tools and annual reassessment tools annually, and when the MCO becomes aware that the member's functional or medical status has changed in a way that may affect needs-based eligibility for their enrolled membership and provides the information to the Iowa Medicaid Medical Services Unit. The Medical Services Unit initially evaluates and annually reevaluates the member's eligibility maintaining review and approval authority. Additionally, any member or provider can request a reassessment at any time. Once the reassessment is complete, the MCO submits the assessment tool and other supporting documentation via upload to the Iowa Medicaid MSU. The State retains authority for determining Medicaid categorical, financial, needs based eligibility or needs-based eligibility and enrolling participants into a Medicaid eligibility category. MCOs track and report assessment and reassessment data, including, but not limited to, reassessment completion date. MCOs are required to notify Iowa Medicaid of any member that has the

appearance of no longer meeting needs-based eligibility. The Iowa Medicaid MSU completes the reevaluation and determines needs-based eligibility. As the State is a neutral third party with approval authority, there is no conflict of interest.

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

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

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

The individual needs assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least twelve months

- The individual needs assistance to obtain and/or maintain employment.
- The individual needs financial assistance to reside independently in the community.
- The individual needs significant assistance to establish or maintain a personal social support system.
- The individual needs assistance with at least one activities of daily living (ADLs) or instrumental activities of daily living (IADLs) to reside independently in the community.
- The individual needs assistance with management and intervention of maladaptive or anti-social behaviors to ensure the safety of the individual and/or others.

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

- A history of inpatient, partial hospitalization, or emergency psychiatric treatment more than once in the individual's life; or
- The individual has a history of continuous professional psychiatric supportive care other than hospitalization; or
- The individual has a history of involvement with the criminal justice system; or
- Services available in the individual's community have not been able to meet the individual's needs; or
- The individual has a history of unemployment or employment in a sheltered setting or poor work history; or
- The individual has a history of homelessness or is at risk of homelessness

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

the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC** waivers)**	**ICF/IID (& ICF/IID LOC waivers)**	Applicable Hospital* (& Hospital LOC waivers)
The individual needs assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least twelve months • The individual needs assistance to obtain and/or maintain employment. • The individual needs financial assistance to reside independently in the community. • The individual needs significant assistance to establish or maintain a personal social support system. • The individual needs assistance with at least one activities of daily living (ADLs) or instrumental activities of daily living (IADLs) to reside independently in the community. • The individual needs assistance with management and intervention of maladaptive or anti-social	"Nursing facility level of care" means that the following conditions are met: 1. The presence of a physical or mental impairment which restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently. 2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible	"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care	"Psychiatric medical institution for children level of care" means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.22(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed

behaviors to ensure the safety of the individual and/or others. **And** The individual meets at least one of the following risk factors: • A history of inpatient, partial hospitalization, or emergency psychiatric treatment more than once in the individual's life; or • The individual has a history of continuous professional psychiatric supportive care other than hospitalization; or • The individual has a history of involvement with the criminal justice system; or • Services available in the individual's community have not been able to meet the individual's needs; or • The individual has a history of unemployment or employment in a sheltered setting or poor work history; or • The individual has a history of homelessness or is at risk of homelessness			

*Long Term Care/Chronic Care Hospital

**LOC= level of care

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

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

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

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

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

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

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

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

a. The setting is integrated in, and facilitates the individual's full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, like individuals without disabilities;

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

Settings:
Home Based Habilitation services can be provided in the following settings:

- Individual member's homes of any type (houses, apartments, condominiums, etc.).
- Members living in their family home of any type.
- Integrated community rental properties available to anyone within the community.

Provider-owned or controlled residential settings including:

- DIAL licensed Residential Care Facility (RCF)16 beds or less.
- DIAL licensed Assisted Living Facility
- Host Home
- Home Based Habilitation Daily Site
- Region designated Intensive Residential Habilitation Service (IRHS) Home

Nonresidential Habilitation services including Day Habilitation, Prevocational, and Supported Employment services occur in integrated community-based settings.

Setting Requirements
The State assures full and ongoing compliance with the HCBS setting requirements at 42 CFR Section 441.710(a) (1) (2) and public input requirements at 42 CFR 441.710(3) (iii).

There are settings where HCBS can be provided that are presumed to meet the HCBS settings rules without need for remediation. These settings, by their nature, are settings that are fully integrated into the community. Although these setting are presumed to be compliant with the final rule without a need for remediation, they are included in Iowa's ongoing monitoring and quality oversight reviews.

In Iowa, these settings may include member owned and controlled residential settings where any HCB services are provided such as:

- Individual member's homes of any type (houses, apartments, condominiums, etc.).
- Members living in their family home of any type.
- Integrated community rental properties available to anyone within the community

Various services may be provided in member owned and controlled residential settings. However, Iowa specifically collected member owned and controlled locations where the HCB services of HBH, and "Other" services were provided through the initial address collection process. In subsequent years of the address collection process, the member-owned or controlled locations underwent the following process:".

To assess the settings identified above to ensure they met the HCBS settings requirements, Iowa Medicaid uses existing processes and enhances, expands, or creates new processes and tools where gaps exist. These processes include:

- Provider quality self-assessment, address collection, and attestation (form #470-4547)
- Quality oversight and review and specifically the SFY17-18 and SFY23 Focused Reviews completed by the QIO HCBS Unit
- Residential Settings Assessments
- Non-Residential Settings Assessments

To ensure settings identified above continue to meet the HCBS settings requirements, Iowa Medicaid will use the following processes to assess HCBS settings for ongoing compliance:

- Provider Quality Self-Assessment tool
- Quality oversight and review of non-residential settings completed by the QIO HCBS Unit.
- Residential Assessments – completed annually by case managers with each member receiving HCB services. Additionally, a Residential Assessment will be completed with members within 30 days of moving to a new residence.

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

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS at 42 CFR §441.301(c)(4)(i) (entire criterion except for "control personal resources), and receive services in the community, like individuals without disabilities.
- The setting, to reside in, is selected by the individual from setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board at 42 CFR §441.301(c)(4)(ii),
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact at 42 CFR §441.301(c)(4)(iv), and
- Facilitates individual choice regarding services and supports, and who provides them at 42 CFR §441.301(c)(4)(v).

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

- Individuals sharing units have a choice of roommate in that setting at 42 CFR §441.301(c)(4)(vi)(B)(2), and
- Individuals have the freedom and support to control their own schedules and activities at 42 CFR §441.301(c)(4)(vi)(C) (entire criterion except for "have access to food at any time").

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

Any setting determined to need CMS heightened scrutiny review and approval will need to receive this approval before receiving HCBS funding in the setting. Providers will be required to submit new HCBS settings to the QIO HCBS Unit.

Reserved.

Reserved.

Reserved

Reserved.

Reserved.

Person-Centered Planning & Service Delivery

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The FFS CM, IHHCC or the member's MCO ensures that the comprehensive service plan :

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

The FFS CM, IHHCC or the member's MCO ensures that the written comprehensive service plan documentation:

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

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

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

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

The Iowa Department of Human Services has developed a computer system named the Institutional and Waiver Authorization and Narrative System (IoWANS) to support certain Medicaid programs. This system assists with tracking information and monitoring the service plan and enforces parameters such as unit and rate caps set by the department.

For1915(i) participants who are not enrolled with an MCO through the Iowa HealthLink, the case manager or IHHCC initiates a request for services through this system, and Iowa Medicaid staff responds to the request for 1915(i) services. Case managers or IHHCCs complete the assessment of the need for services and submit it to the Iowa Medicaid Medical Services Unit for evaluation of program eligibility. The case manager or IHHCC is also responsible for entering the service plan information such as the services to be received, the effective dates, the amount of each service, and the selected provider into IoWANS, where it is reviewed for authorization by Iowa Medicaid Medical Services staff.

For 1915(i) participants who are enrolled in the Iowa HealthLink, the MCOs have established a process for reviewing treatment plans and authorizing units of services. A determination is made by the MCO for the appropriate services and units based on the assessment, treatment plan and other services the member may be receiving. The State reviewed the MCO service planning process during the readiness review and retains oversight of the MCO person-centered service planning process through a variety of monitoring and oversight strategies as described in the Quality Improvement Strategy Section.

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

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

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	HCBS Case Management
Service Definition (Scope):	
Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Individuals who receive Targeted Case Management or Integrated Health Home services under the Medicaid State plan cannot also receive case management under Section 1915(i).	

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

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

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

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

(Choose each that applies):

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Case Management Provider	Iowa Department of Human Services, Iowa Medicaid	Verified at initial certification and thereafter based on the length of the certification (either 270 days, 1 year, or 3 years)

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

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Habilitation

Service Definition (Scope)*:*

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

Components of this service include the following:

Home-based Habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living, working and recreating in the community. Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

1) Adaptive skill development;
2) Assistance with activities of daily living to address daily living needs;
3) Assistance with symptom management and participation in mental health treatment;
4) Assistance with accessing physical and mental health care treatment, communication, and implementation of health care recommendations and treatment;
5) Assistance with accessing and participating in substance use disorder treatment and services;
6) Assistance with medication administration and medication management;
7) Assistance with understanding communication whether verbal or written;
8) Community inclusion and active participation in the community;
9) Transportation;
10) Adult educational supports, which may include assistance and support with enrolling in educational opportunities and participation in education and training;
11) Social and leisure skill development;
12) Personal care; and
13) Protective oversight and supervision.

Setting requirements. Home-based habilitation services shall occur in the member's home and community.

1) A member may live in the member's own home, within the home of the member's family or legal representative, or in another community living arrangement that meets the criteria in 441—subrule 77.25(5).
2) A member living with the member's family or legal representative is not subject to the criteria in 441—paragraphs 77.25(8) "c" and 77.25(8) "d."
3) A member may not reside in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

Remote Support HBH Service Delivery Model

Remote Support is the provision of Home-Based Habilitation by a trained remote support professional who is in a remote location and is engaged with a person through enabling technology that utilizes live two-way communication in addition to or in place of on-site staffing. Remote support is not a service. It is an available delivery option of the Home-Based Habilitation service to meet an individual's health, safety and other support needs as needed when it:

- Is chosen and preferred as a service delivery method by the person or their guardian (if applicable)
- Appropriately meets the individual's assessed needs.
- Is provided within the scope of the service being delivered.
- Is provided as specified in the individual's support plan.

HBH delivered remotely assists individuals to avoid institutional placement or placement in a more restrictive living environment by fostering independence and security by combining technology and service to allow for direct contact with trained staff when the individual needs that contact.

Delivery of HBH services remotely assists individuals to enhance and increase their independence by providing a realistic, noninvasive way for individuals to build life skills and familiarity in their level of independence with a sense of security.

Delivery of HBH services remotely can assist individuals to live more independently or support a safe transition to independent living while enhancing their self-advocacy skills and increase opportunities for participating in the community.

HBH is delivered remotely by awake; alert remote HBH support professionals whose primary duties are to provide remote supports from the HBH provider's secure remote

location. To ensure safety and Health Insurance Portability and Accountability Act (HIPAA) compliance, this location should have appropriate, stable, and redundant connections. This should include, but is not limited to, backup generators or back battery, multiple internet service connections.

Paid or unpaid backup support may be provided as specified in the individual's service plan. Paid backup support is provided on a paid basis by a provider of Home-Based Habilitation that is both the primary point of contact for the remote supports vendor and the entity to send paid staff person(s) on-site when needed. Unpaid backup support may be provided by a family member, friend, or other person who the individual chooses. The person-centered service plan (PCSP) will reflect how the HBH delivered remotely is being used to meet the goals for independent living and assessed needs, including health, safety, and welfare needs.

The PCSP may contain multiple habilitative services, however services may not occur simultaneously or on the same date of service at the same time. The case manager, community-based case manager, or care coordinator is responsible to ensure that there is no overlap or duplication of services authorized in the PCSP.

HBH Remote Support System Design

The following are requirements of a remote supports system design when utilized to replace in-person direct support service delivery:

• The provider must have safeguards and/or backup system such as battery or generator for the electronic devices in place at the location of the HBH remote delivery support staff and the individual's home in the event of electrical outages.

• The provider must have written policy and procedures approved by the Iowa Medicaid Quality Improvement Organization (QIO) HCBS unit that defines emergency situations and details.

- How remote and backup staff will respond to each. Examples include:
- Fire, medical crises, stranger in the home, violence between individuals and any other situation that appears to threaten the health or welfare of the individual.
- Emergency response drills must be carried out once per quarter per shift in each home.
- equipped with and capable of utilizing remote supports.
- Documentation of the drills must be available for review upon request.
- When used to replace in-person direct support service delivery, the remote monitoring staff shall generate service documentation on each individual for the period when remote supports are provided.

• The provider must have backup procedures for system failure (for example, prolonged power outage), fire or weather emergency, individual medical issue or personal emergency in place and detailed in writing for each site utilizing the system as well as in each individual's PCSP. This plan should specify the staff person or persons to be contacted by remote support monitoring staff who will be responsible for responding to these situations and traveling to the individual's home, including any previously identified paid or unpaid backup support responder.

• The remote supports system may receive notification of smoke/heat alarm activation. Recognizing remote supports will vary based on individual needs assessments, notifications are not intended to replace fire/smoke/heat detection systems nor drills as required.

• The remote support system must have in place regular routine of testing that ensures the system and devices are working properly.

• The remote supports system must have two-way (at minimum, full duplex) audio communication capabilities to allow monitoring staff to effectively interact with and address the needs of individuals in each living site, including emergency situations when the individual may not be able to use the telephone.

• HBH remote support delivery staff will have access to visual (video) oversight of areas in individual's residential living sites as deemed necessary by the IDT to meet the individual's needs based on informed consent of the member and/ or their legal representative.

• HBH remote support delivery staff may not be located in the home of the individual receiving remote supports.

• A secure (compliant with the HIPAA) network system requiring authentication, authorization and encryption of data must be in place to ensure access to computer vision, audio, sensor, or written information is limited to authorized individuals identified in the member's service plan, and state entities as necessary for the oversight of service delivery.

• The members must be made aware of the operating hours of the equipment

• For situations involving remote supports of individuals needing 24-hour support, if an individual indicates that they no longer want to receive their service through the remote supports system the following protocol will be implemented:

- The remote support professional or other person who becomes aware of the member's desire to change to all in person supports will notify the provider to request an IDT meeting to discuss the request and identify appropriate alternative.

Remote Support Service Requirements

The HBH provider must have written policy and procedures approved by the Iowa Medicaid Quality Improvement Organization (QIO) HCBS unit that defines emergency situations and details. How remote and backup staff will respond to each. Examples include:

o Fire, medical crises, stranger in the home, violence between individuals and any other situation that appears to threaten the health or welfare of the individual.

o Emergency response drills must be carried out once per quarter per shift in each home equipped with and capable of utilizing remote supports.

• Documentation of the drills must be available for review upon request.

o When used to replace in-person direct support service delivery, the remote monitoring staff shall generate service documentation on each individual for the period when remote supports are provided.

HBH Remote Support Delivery Staff (Remote Support Professionals)

The following are requirements for HBH remote support professionals when remote supports are used in place of in-person direct support service delivery:

• At the time of monitoring, the remote supports professionals must be awake and may not have duties other than the oversight and support of individuals receiving remote support.

• The remote supports professionals will assess any urgent situation at an individual's home and call 911 emergency personnel first, if it is deemed necessary, and then call the backup staff person. The remote supports professionals will stay engaged with the individuals at the home during an urgent situation until the backup staff or emergency personnel arrive.

• If computer vision or video is used, oversight of an individual's home must be done in real time by an awake remote supports professional located outside of the individual's home using telecommunications/broadband, the equivalent or better, connection.

• HBH Remote Support Delivery Staff shall maintain a file on each individual in each home monitored that includes a current photograph of each individual, which must be updated if significant physical changes occur, and at least annually. The file shall also include pertinent information on each individual, noting facts that would aid in ensuring the individuals' safety.

• The remote supports professionals must have detailed and current written protocols for responding to the needs of each individual, including contact information for staff to supply on-site support at the individual's residential living site, when necessary.

•The delivery of in person HBH by a direct support professional and the delivery of remote HBH by a remote support professional may not occur at the same time.

Backup On-Site HBH

The following are requirements for stand-by /backup on-site HBH staff.

• The backup on-site HBH staff shall respond and arrive at the individual's residential living site within the timeframe identified in the individuals PCSP, from the time the incident is identified by the HBH remote support professionals, and the on-site backup HBH staff acknowledges receipt of the notification by the HBH remote monitoring staff.

• Backup on-site HBH staff will assist the individual in the home as needed when the remote delivery of HBH does not meet the needs of the individual.

Service Plan

When a person chooses to receive home-based habilitation services (HBH) remotely, the individual's person-centered service plan must reflect the remotes supports plan and document all the following:

- The individual's and/or guardians informed consent.
- The individual's assessed needs and identified goals for HBH that can be met using remote support.
- How the HBH delivered remotely will support the person to live and work in the most integrated community settings.
- The individual's needs that must be met with in-person HBH services, and those that will be met with remote HBH services.
- The hours per day the member will receive in-person HBH and the hours per day that the member will receive HBH remotely.
- The names, relationships and contact information for unpaid back-up support that will be available to the member.

- The plan for providing habilitation services in-person or remotely based on the individual's needs to ensure their health and safety.
- The training provided to the individual on the use of the technology and equipment.
- The individual's control and use of the equipment
- Whether the person or their guardian (if applicable) agrees to the use of video monitoring or cameras for service delivery and has provided informed consent for the use of video monitoring or cameras.
- The amount, frequency, and duration that HBH can be delivered remotely.
- How visitors are informed of the use of cameras and video monitors in the setting if video monitoring or cameras are being utilized under this service. Use of the system may be restricted to certain hours through the PCSPs of the individuals involved.

Assessment

Through an assessment by the HBH remote support provider with input from the individual and their Interdisciplinary Team (IDT) the member's ability to be supported safely through remote support is identified.

Through an assessment by the remote support provider with input from the individual and their IDT, the location of the devices or monitors will be determined to best meet the individual's needs.

Informed Consent

Informed consent by the individual using the service, their guardian and other individuals and their guardians residing in the home must be obtained and clearly state the parameters for delivery of the HBH service remotely.

Each individual, guardian, and IDT must be made aware of both the benefits and risks of the operating parameters and limitations.

Informed consent documents must be acknowledged in writing, signed, and dated by the individual, guardian, case manager and provider agency representative, as appropriate prior to the delivery of HBH through remote support. A copy of the consent shall be maintained by the case manager, the guardian (if applicable) and in the agency provider's member service record.

If the individual desires to withdraw consent, they would notify the case manager. As informed consent is a prerequisite for utilization of remote support services, a meeting of the IDT would be needed to discuss available options for any necessary alternate supports. All residing adult and youth individuals, their guardians and their support teams impacted by the decision to withdraw consent must be immediately informed of the decision and use of remote supports in the setting must be discontinued.

Informed consent for remote supports must be reviewed annually as part of the person-centered planning process.

Privacy

Remote Support Professionals must:

- Respect and always maintain the individual's privacy, including when the person is in settings typically used by the public.

- Respect and always maintain the individual's privacy, including when scheduled or intermittent/as-needed support includes responding to an individual's health, safety, and other support needs for personal cares.
- Only use cameras in bedrooms or bathrooms when the IDT has identified a specific support need directly related to the member's health or safety risk in the person-centered service plan and the member, and their legal representative has given informed consent for the use of cameras in the member's bedroom or bathroom to specifically mitigate the risk when in-person supports are not present.
    - For members who share a bathroom, each member must have an identified health or safety risk justifying the use of the camera and each must provide informed consent for the use of the camera. For members for whom there is not an identified health or safety need for cameras in the bathroom and for whom there is no informed consent for the use of a camera in the bathroom, the camera must have the functionality that allows it to be shut off by the member or the Remote Support Professional while that member is using the bathroom.
    - For members sharing a bedroom, each member must consent to the placement of a camera in the bedroom. If both members do not consent, then the camera may not be placed in the bedroom.

The member's case manager, care coordinator or community-based case manager is responsible for ensuring that the HBH provider agency has provided the appropriate training on the use of the technology and equipment within the home including the how to disable or shut off the technology and equipment including cameras and monitors as needed prior to initiation of HBH remote service delivery. The record of the training that occurs with the member on the use of the technology and equipment will be documented in the member's service record and reviewed regularly by the case manager, care coordinator or community-based case manager.

The individual's case manager, care coordinator or community-based case manager is responsible for monitoring the services in the person-centered service plan which includes at a minimum monthly contact with the individual or their representative and visiting individuals in their place of residence on a quarterly basis. As part of the monitoring activities the case manager, care coordinator or community-based case manager will review the receipt of HBH with the member and ensure that the delivery of HBH through remote support continues to meet the individual's service needs. This regular review will include a review of the member's use of the equipment, informed consent for the mode of service delivery and the overall satisfaction with the delivery of HBH remotely. The HCBS QIO and the MCOs also provide oversight of service delivery through the quality monitoring and oversight of the HBH providers.

The agency service provider responsible for responding to an individual's health, safety, and other support needs through remote support must:

1. Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA).

2. Comply with the data privacy laws, restrictions and guidelines.
3. Ensure that service documentation occurs during remote support delivery in accordance with the 441-79.3

HBH Host Home Service Delivery Model
A Host Home is a community-based family home setting whose owner or renter provides home and community-based services (HCBS) Waiver Home-Based Habilitation services to no more than (2) individuals who reside with the owner or renter in their primary residence and is approved for those services as an independent contractor of a community-based HBH service agency.

Host Home is an available service delivery option through the HBH service to meet a member's health, safety and other support needs as needed when it:
*Is chosen and preferred as a service delivery method by the person or their guardian (if applicable)
*Appropriately meets the member's assessed needs.
*Is provided within the scope of the service being delivered.
*Is provided as specified in the member's support plan.

HBH delivered in a Host Home Service Requirements

Assessment
Through an assessment by the HBH agency provider with input from the member and their Interdisciplinary Team (IDT) the member's ability to be supported safely through the Host Home model is identified.
Through an assessment by the HBH agency provider with input from the individual and their IDT, the desired location of the Host Home will be determined to best meet the member's needs.
Through an assessment by the HBH agency provider of potential Host Home Hosts, potential matching Host Homes will be identified.

Informed Consent
Informed consent of delivery of HBH in the Host Home by the Host Home provider by the individual using the service, their guardian must be obtained. Each member, guardian and IDT must be made aware of both the benefits and risks of the Host Home service delivery model.
Informed consent documents must be acknowledged in writing, signed, and dated by the individual, guardian, case manager and provider agency representative, as appropriate. A copy of the consent shall be maintained by the case manager, the guardian (if applicable) and in the provider agency file.
If the individual desires to withdraw consent, sever the residential agreement, and transfer from the Host Home to a provider owned and controlled HBH setting, the member, their guardian or the Host must notify the HBH provider agency and the member's case manager. A meeting of the IDT would be needed to discuss available options for any necessary alternative services and supports.

Privacy
Host Home HBH service providers must:
* Respect and always maintain the member's privacy, including when the person is in settings typically used by the public.
* Respect and always maintain the member's privacy, including when scheduled or intermittent/as-needed support includes responding to a member's health, safety, and other support needs for personal cares.

Members may choose to receive HBH through the telehealth service delivery option. Providers delivering HBH through the Telehealth* delivery option must demonstrate policies and procedures that include:

- Compliance with all state requirements related to telehealth as described in Iowa Code 514c.34
- HIPAA compliant platforms.
- Client support given when client needs include accessibility, translation, or limited auditory or visual capacities are present.
- Have a contingency plan for provision of services if technology fails.
- Professionals do not practice outside of their respective scope; and
- Assessment of clients and caregivers that identifies a client's ability to participate in and outlines any accommodations needed while using Telehealth.
- In-person visit is not a prerequisite for the delivery of HBH through Telehealth.

*"Telehealth" means the delivery of HBH services through the use of real-time interactive audio and video, or other real-time interactive electronic media, regardless of where the health care professional and the covered person are each located. "Telehealth" does not include the delivery of health care services delivered solely through an audio-only telephone, electronic mail message, or facsimile transmission.

HBH services delivered via telehealth will be delivered in a setting or location that protects the Habilitation participants privacy and may not occur in settings such as a bathroom.

The in-person delivery of HBH by a direct support professional and the delivery of HBH through telehealth or remote support professional may not occur at the same time.

2.) Enabling Technology for Remote Support

"Enabling technology" means the technology that makes the on demand remote supervision and support possible and includes a device, product system, or engineered solution whether acquired commercially, modified, or customized that addresses an individual's needs and outcomes identified in his or her individual service plan. The service is for the direct benefit of the individual in maintaining or improving independence and functional capabilities. Remote support and monitoring will assist the individual to fully integrate into the community, participate in community activities, and avoid isolation.

Enabling technology may cover evaluation of the need for enabling technology and, if appropriate, subsequent selection of a device needed to improve a participant's ability to perform activities of daily living, control or access his/her environment or communicate. This service also includes equipment rental during a trial period, customization, and rental of equipment during periods of repair.

Enabling technology (assessments only) remote support, is the following: Remote Support is the provision of Home-Based Habilitation by a trained remote support professional who is in a remote location and is engaged with a person through enabling technology that utilizes live two-way communication in addition to or in place of on-site staffing.

The Enabling Technology assessment process is executed by the HBH Provider Agency working directly with the member's guardian or legal representative and the case manager, care coordinator or Community-Based Case Manager. The assessment is interview based and intended to assess the member's interest, readiness, and need for Enabling Technology. The Enabling Technology Screening tool is utilized to inform the person-centered planning process. The Enabling Technology Screening tool is completed after the member has expressed an interest to receive HBH through the Remote Support service delivery model. The responses to the Enabling Technology Screening Tool are included in the Person-Centered Service Plan. If the results of the Enabling Technology Screening Tool indicate there is an overall interest, readiness, and need for Enabling Technology, the Case Manager, Care Coordinator or Case Manager along with the IDT will address the delivery of HBH through remote supports including the types of technology to be utilized in the delivery of remote supports.

Remote supports are delivered by awake; alert remote support professionals whose primary duties are to provide remote supports from the HBH provider's secure remote location. To ensure safety and Health Insurance Portability and Accountability Act (HIPAA) compliance, this location should have appropriate, stable, and redundant connections. This should include, but is not limited to, backup generators or back battery, multiple internet service connections.

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

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

community employment. Day habilitation activities may include:

(1) Identifying the member's interests, preferences, skills, strengths, and contributions,
(2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,
(3) Planning and coordination of the member's individualized daily and weekly day habilitation schedule,
(4) Developing skills and competencies necessary to pursue competitive integrated employment.
(5) Participating in community activities related to hobbies, leisure, personal health, and wellness,
(6) Participating in community activities related to cultural, civic, and religious interests,
(7) Participating in adult learning opportunities,
(8) Participating in volunteer opportunities,
(9) Training and education in self-advocacy and self-determination to support the member's ability to make informed choices about where to live, work, and recreate,
(10) Assistance with behavior management and self-regulation,
(11) Use of transportation and other community resources,
(12) Assistance with developing and maintaining natural relationships in the community,
(13) Assistance with identifying and using natural supports,
(14) Assistance with accessing financial literacy and benefits education,
(15) Other activities deemed necessary to assist the member with full participation in the community,

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

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

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

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

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

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

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

community, other than those providing direct services, to the same extent as individuals without disabilities.
Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member's residence. Family training may be provided in the member's home.
Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).
Unit of service. A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).
Concurrent services. A member's comprehensive service plan may include two or more types of nonresidential habilitation services (e.g., day habilitation, individual supported employment, long-term job coaching, small-group supported employment, and prevocational services). However, more than one service may not be billed during the same period of time (e.g., the same hour).
Transportation. When transportation is provided to the day habilitation service location from the member's home and from the day habilitation service location to the member's home, the day habilitation provider may bill for the time spent transporting the member.

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

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

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

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

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

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

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

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

The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities

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

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

Prevocational Service Requirements

To participate in prevocational services:

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

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

1. Special education and related services as defined in the Individuals with Disabilities Education

Act (20 U.S.C. 1401 et seq.); or

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

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

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to

ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

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

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

4) Supported Employment

Individual Supported Employment

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

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

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

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

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

Individual employment strategies include but are not limited to:

- Customized employment,
- Individual placement and support, and
- Supported self-employment.

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

Supported Self-Employment

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

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

Aid to the member in identifying potential business opportunities.

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

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

Long-Term Job Coaching

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

Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in

individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

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

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

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

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

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

Service Activities

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

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

Self-Employment Long-Term Job Coaching

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

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

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

Small Group Employment (2 to 8 Individuals)

Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include, but are not limited to:

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

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

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

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

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

- Employment assessment
- Person-centered employment planning
- Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave)
- Job analysis
- On-the-job training and systematic instruction
- Job coaching
- Transportation planning and training
- Benefits education

- Career exploration services leading to career advancement outcomes
- Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting
- Transportation of the member during service hours

Individual Placement and Support
Individual Placement and Support (IPS) means the evidenced based practice of supported employment (SE) that is guided by IPS Practice principles outlined by the IPS Employment Center at Westat, and as measured to be "exemplary", "good", "fair , and "not supported employment" by their most recently published 25-item Fidelity Scale available online at https://ipsworks.org/wp-content/uploads/2017/08/ips-fidelity-manual-3rd-edition_2-4-16.pdf

IPS shall include:
1. Development of the career profile. The career profile includes previous work experience, goals, preferences, strengths, barriers, skills, disclosure preferences, career advancement/education/plan for graduation.
2. IPS team members are fully integrated with the behavioral health team, including participation in routine staffing meetings regarding IPS clients.
3. Addressing barriers to employment. Barriers to employment may be actual or perceived and support may include addressing justice system involvement, a lack of work history, limited housing, childcare, and transportation.
4. Rapid job search and systematic job development. Certified Employment Specialists (CESs) help members seek jobs directly, and do not provide extensive pre-employment assessment and training, or intermediate work experiences. The job process begins early, within 30 days of starting IPS services. This rapid job search is supported by CESs developing relationships with employers through multiple face-to-face meetings. CESs take time to learn about the employers' needs and the work environment while gathering information about job opportunities that might be a good fit for individuals they are working with.
5. Disclosure. Assuring that the individual makes an informed decision on disclosure of a disability to a prospective or current employer.
6. Job Accommodations and Assistive Technology. CESs identify and address job accommodations or technology needs.
7. Ongoing benefits counseling. CESs provide information on available work incentive programs, or referral to professional benefits counselors for a personalized work incentives plan for any state or federal entitlement.
8. Time unlimited follow along supports. These supports are planned for early in the employment process, are personalized, and follow the individual for as long as they need support. The focus is supporting the individual in becoming as independent as possible, and involving family members, co-workers, and other natural supports. These supports can be provided on or off the job site and focus on the continued acquisition and development of skills needed to maintain employment.

Service Requirements for All Supported Employment Services
Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to

and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

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

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

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

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

Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

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

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

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

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

For dates of service on or before March 31, 2022, the Home-based habilitation services shall be available based on the member's assessed needs using the utilization management criteria in effect as of 04/01/2016.

For dates of service beginning April 1, 2022, Home-based habilitation services shall be available to members based on the member's most current LOCUS/CALOCUS actual disposition score, according to the following criteria:

(1) Intensive IV services are provided 24 hours per day. To be eligible for intensive IV services, a member must meet the following criteria:

1. The member has a LOCUS/CALOCUS actual disposition of level six medically managed residential services, and
2. The member meets the criteria in 441—subparagraph 25.6(8)*"c"*(3).

(2) Intensive III services are provided 17 to 24 hours per day. To be eligible for intensive III services, the member must have a LOCUS/CALOCUS actual disposition of level five medically monitored residential services.
(3) Intensive II services are provided 13 to 16.75 hours per day. To be eligible for intensive II services, the member must have a LOCUS/CALOCUS actual disposition of level four medically monitored non-residential services.
(4) Intensive I services are provided 9 to 12.75 hours per day. To be eligible for intensive I service, the member must have a LOCUS/CALOCUS actual disposition of level three high intensity community-based services.
(5) Medium need services are provided 4.25 to 8.75 hours per day as needed. To be eligible for medium need services, the member must have a LOCUS/CALOCUS actual disposition of level two low intensity community-based services.
(6) Recovery transitional services are provided 2.25 to 4 hours per day as needed. To be eligible for recovery transitional services, the member must have a LOCUS/CALOCUS actual disposition of level one recovery maintenance and health management.
(7) High recovery services are provided 0.25 to 2 hours per day as needed. To be eligible for high recovery services, the member must have a LOCUS/CALOCUS actual disposition of level zero.

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

☑ Categorically needy *(specify limits):*

A unit of home-based habilitation is a day. The member is assigned a Home-Based Habilitation Tier based on the actual disposition score of the LOCUS/CALOCUS tool. For Intensive IV Tier 7 the member must also meet the criteria in 441.25.6(8).

Tier	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	Tier 7
Description	High Recovery	Recovery Transitional	Medium Need	Intensive I	Intensive II	Intensive III	Intensive IV
Hours of Staff Supervision and Support	.25 to 2 hours per day as needed	2.25 to 4 hours per day as needed	4.25 to 8.75 hours per day as needed	9 to 12.75 hours per day	13 to 16.75 hours per day	17 to 24 hours per day	24 hours per day
LOCUS Composite Score	**07-09**	**10-13**	**14-16**	**17-19**	**20-22**	**23-27**	**28+**

Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

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

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

Day habilitation payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

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

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

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

Prevocational services are reimbursed as an hourly unit of service.

Career exploration is an hourly unit of service.

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

Prevocational Service Limitation

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

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

Exclusions

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

Supported Employment (SE) services.
Individual SE is reimbursed as an hourly unit of service.
Small Group SE is reimbursed as a 15 min unit of service.
Long Term Job Coaching SE is reimbursed as a monthly unit of service.
Individual Placement and Support (IPS) SE is reimbursed for each outcome achieved for the member participating in the IPS SE model

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

Individual SE
40 units for the initial authorization and 20 units for an extended authorization.
One initial and, if necessary, one extended authorization permitted per year not to exceed a total of 60 hourly units per year.

Long Term Job Coaching
Tier 1= 1 contact/month
Tier 2 = 2-8 hours/month
Tier 3 = 9-16 hours/month
Tier 4 = 17-25 hours/month
Tier 5 = 26 or more hours per month

Small Group SE
Tier 1 - Groups of 2-4
Tier 2 - Groups of 5-6
Tier 3 - Groups of 7-8

Individual Placement and Support (IPS) SE. Outcomes are as follows:
1. Outcome #1 completed employment plan
2. Outcome #2 first day of successful job placement
3. Outcome #3 forty-five days successful job retention
4. Outcome #4 ninety days successful job retention.

☑ Medically Needy

A unit of home-based habilitation is a day. The member is assigned a Home-Based Habilitation Tier based on the actual disposition score of the LOCUS/CALOCUS tool. For Intensive IV Tier 7 the member must also meet the criteria in 441.25.6(8).

Tier	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Procedure Code/ Modifier	H2016 UA	H2016 UB	H2016 UC	H2016 UD	H2016 U8	H2016 U9
Description	High Recovery	Recovery Transitional	Medium Need	Intensive I	Intensive II	Intensive III
Hours of Staff Supervision and Support	.25 to 2 hours per day as needed	2.25 to 4 hours per day as needed	4.25 to 8.75 hours per day as needed	9 to 12.75 hours per day	13 to 16.75 hours per day	17 to 24 hours per day
LOCUS Composite Score	**07-09**	**10-13**	**14-16**	**17-19**	**20-22**	**23-27**

Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or “bundled” service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

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

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

Day habilitation payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

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

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

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

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

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

Prevocational Service Limitations

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

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

Exclusions

- Prevocational services payment shall not be made for the following:

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

Supported Employment (SE) services.
Individual SE is reimbursed as an hourly unit of service.
Small Group SE is reimbursed as a 15 min unit of service.
Long Term Job Coaching SE is reimbursed as a monthly unit of service.
Individual Placement and Support (IPS) SE is reimbursed for each outcome achieved for the member participating in the IPS SE model
The current HCBS Prevocational and Supported Employment fee schedule may be located at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule

Individual SE
40 units for the initial authorization and 20 units for an extended authorization.
One initial and, if necessary, one extended authorization permitted per year not to exceed a total of 60 hourly units per year.

Long Term Job Coaching
Tier 1= 1 contact/month
Tier 2 = 2-8 hours/month
Tier 3 = 9-16 hours/month
Tier 4 = 17-25 hours/month
Tier 5 = 26 or more hours per month

Small Group SE
Tier 1 - Groups of 2-4
Tier 2 - Groups of 5-6
Tier 3 - Groups of 7-8

Individual Placement and Support (IPS) SE
Outcomes are as follows:
1. Outcome #1 completed employment plan
2. Outcome #2 first day of successful job placement
3. Outcome #3 forty-five days successful job retention
4. Outcome #4 ninety days successful job retention.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home-based habilitation providers		Meet any of the following: • Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) • Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) • Accredited by the Council on Accreditation (COA) • Accredited by the Council on Quality and Leadership (CQL) • Certified by the bureau of medical and long-term services and supports (MLTSS) of Iowa Medicaid as a provider of Supported Community Living for the HCBS ID Waiver under 441-IAC 77.37(1) through 77.37(14) or the HCBS BI Waiver under 441-IAC 77.39(1) through 77.39(10) and 77.39(13). • Certified by the department as a provider of Supported Community Living under 441-IAC 24.2 through 24.4(8) and 24.2(12). • Meet any of the above and meet the criteria at 441 IAC subrule 25.6(8) including designation as an intensive residential services provider by a Mental Health Disability Services Region.	Direct support staff providing home-based habilitation services shall meet the following minimum qualifications in addition to the other requirements outlined in this rule: (1) A person providing direct support shall be at least 18 years old and have a high school diploma or its equivalent. (2) A person providing direct support shall not be an immediate family member of the member receiving services. (3) A person providing direct support to members receiving intensive residential habilitation services shall complete 48 hours of training within the first year of employment in mental health and multi-occurring conditions pursuant to 441—subrule 25.6(8). (4) A person providing direct support to members receiving home-based habilitation services shall complete a minimum of 24 hours of training within the first year of employment in mental health and multi-occurring conditions, including but not limited to the following topics: 1. Mental health diagnoses, symptomology, and treatment; 2. Intervention strategies that may include applied behavioral analysis, motivational interviewing, or other evidence-based practices; 3. Crisis management, intervention, and de-escalation;

Intensive Residential Home-Based Habilitation Providers			4. Psychiatric medications, common medications, and potential side effects; 5. Member-specific medication protocols, supervision of self-administration of medication, and documentation; 6. Substance use disorders and treatment; 7. Other diagnoses or conditions present in the population served; and 8. Individual-person-centered service plan, crisis plan, and behavioral support plan implementation. (5) A person providing direct support to members receiving home-based habilitation services shall complete a minimum of 12 hours of training annually on the topics listed in subparagraph 77.25(8) "b" (4), or other topics related to serving individuals with severe and persistent mental illness.
Enabling Technology for Remote Support providers		Providers delivering Enabling Technology needs must be one of the following professionals: • Providers enrolled to deliver HCBS BI or ID waiver Supported Community Living • Providers enrolled to deliver HCBS Habilitation Home-Based Habilitation • Others qualified by training or experience to provide enabling technology.	The support planning team will identify the person(s) or entity experienced in the area of Enabling Technology and its application for people with disabilities as qualified to provide and ensure that: a) an evaluation of the participant's need for an assessment of potential for successful utilization of enabling devices occurs; b) the appropriate and cost-effective device is selected from available options;

			c) the appropriate device is procured; d) training and technical assistance to the participant, caregiver and staff for the proper utilization of the device occurs; and e) appropriate evaluation methods are developed to assure that the intended outcome(s) of the technology is achieved. Enabling technology equipment services must provide a cost-effective, appropriate means of meeting the needs defined in the member's person-centered service plan. All items shall meet applicable standards of manufacture, design, and installation.
Day Habilitation providers		Meet any of the following: • Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) • Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) • Accredited by the Council on Accreditation (COA) • Accredited by the Council on Quality and Leadership (CQL) • Accredited by the International Center for Clubhouse Development (ICCD)	Direct support staff providing day habilitation services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule: (1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent degree. A person providing direct support with line-of sight supervision shall be 16 years of age or older. (2) A person providing direct support shall not be an immediate family member of the member

		• Certified by the bureau of medical and long-term services and supports (MLTSS) of Iowa Medicaid as a provider as a provider of Day Habilitation for the HCBS ID Waiver under 441-IAC 77.37(13) and 77.37(27). • Certified by the department as a provider of Day Treatment under 441-IAC 24.2 through 24.4(8) and 24.4(10) or Supported Community Living under 441-IAC 24.2 through 24.4(8) and 24.2(12).	(3) A person providing direct support shall, within six months of hire or within six months of February 1, 2021, complete at least 9.5 hours of training in supporting members in the activities listed in 701—paragraph 78.27(8) “a,” as offered through DirectCourse or Relias or other nationally recognized training curriculum. (4) A person providing direct support shall annually complete 4 hours of continuing education in supporting members in the activities listed in 701—paragraph 78.27(8) “a,” as offered through DirectCourse or Relias or other nationally recognized training curriculum
Prevocational habilitation providers		Meet any of the following: • Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) • Accredited by the Council on Quality and Leadership (CQL) • Accredited by the International Center for Clubhouse Development (ICCD) • Certified by the bureau of medical and long-term services and supports (MLTSS) of Iowa Medicaid as a provider of Prevocational services for the HCBS ID Waiver under 441-IAC 77.37(13) and 77.37(26) or the HCBS BI Waiver under 441-IAC 77.39(22).	Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to: (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act. (2) Member vacation, sick leave and holiday compensation. (3) Procedures for payment schedules and pay scale. (4) Procedures for provision of workers’ compensation insurance. (5) Procedures for the determination and review of commensurate wages.

			Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule: (1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent degree. A person providing

			direct support with line-of-sight supervision shall be 16 years of age or older. (2) A person providing direct support shall not be an immediate family member of the member. (3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment service training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program. (4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually
Supported employment habilitation providers		Meet any of the following: • Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) • Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) • Accredited by the Council on Accreditation (COA) • Accredited by the Council on Quality and Leadership (CQL) • Accredited by the International Center for Clubhouse Development (ICCD) • Certified by the bureau of medical and long-term services and supports (MLTSS) of Iowa Medicaid as a provider as a provider of Supported Employment for the HCBS ID Waiver under 441-IAC 77.37(1)	Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to: (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act. (2) Member vacation, sick leave and holiday compensation. (3) Procedures for payment schedules and pay scale. (4) Procedures for provision of workers' compensation insurance. (5) Procedures for the determination and review of commensurate wages. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum

Individual Placement and Support SE Providers		through 77.37(13) and 77.37(16) or the HCBS BI waiver under 441-IAC 77.39(1) through 77.39(10) and 77.39(15).	qualifications in addition to other requirements outlined in administrative rule: (1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire. (2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching. (3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

			(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually 1. Providers shall be accredited to provide supported employment and have provided supported employment for a minimum of two years. 2. Providers shall demonstrate adequate funding has been secured for the training and technical assistance required for IPS implementation. Adequate funding is defined as at least the amount required for the start-up of one IPS team to complete all phases of IPS implementation. Evidence of such funding shall be made available to the department at the time of enrollment. Evidence may include a written funding agreement or other documentation from the funder 3. Providers shall receive training and technical assistance throughout IPS implementation from an IPS trainer. Evidence of the IPS team's agreement for such training and technical assistance shall be made available to the department at the time of enrollment. 4. Prospective IPS teams shall complete IPS implementation as defined in subrule 77.25(1) subrule 77.25(1) and as outlined by the IPS Center at Westat

			5. Prospective IPS teams are provisionally approved until the IPS team has obtained at least a "fair" score on a baseline fidelity review completed by IPS reviewers. a) (Provisionally approved IPS teams shall complete IPS implementation phases 1 through 4a within twelve12 months of enrolling. b) (Upon completion of IPS implementation phase 4a, provisionally approved IPS teams shall deliver IPS services according to the IPS outcomes model. c) (Upon completion of IPS implementation phase 7, IPS teams are qualified to deliver IPS services, subject to the following: i. IPS teams must obtain a baseline fidelity review score of "fair" or better within 14 months of completion of IPS implementation phase 1. The fidelity review must be completed by IPS reviewers. The fidelity reviews shall be provided to the department upon receipt by the IPS team. ii. In the event an IPS team fails to achieve a fidelity score of "fair" or better, the IPS team shall receive technical assistance to address areas recommended for improvement as identified in the fidelity review. If the subsequent fidelity review results in a

			score of less than “fair” fidelity, the IPS team will be provisionally approved for no more than 12 months or until the fidelity score again reaches” “fair” fidelity, whichever date is earliest. iii. IPS teams who do not achieve a “fair” fidelity score within 12 months from being provisionally approved will no longer be qualified to deliver IPS services until they again reach the minimum “fair” fidelity score.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home-based habilitation providers	Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit	Verified at initial certification and thereafter based on the length of certification: • Either 270 days, 1 year, or 3 years when certified by Iowa Medicaid as a provider for HCBS ID or BI Waivers or certified under IAC 441-24 • Either 1 year or 3 years when accredited by CARF; either 3 years or 4 years when accredited by COA • 3 years when accredited by JCAHO • 4 years when accredited by CQL
	MCO	Verified at initial certification and thereafter based on the length of the certification.

Enabling Technology for Remote Support	Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit	Verified at initial enrollment and every five years thereafter
Day habilitation providers	Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services unit	Verified at initial certification and thereafter based on the length of certification: • Either 270 days, 1 year, or 3 years when certified by the

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

	MCO		• 4 years when accredited by CQL Verified at initial certification and thereafter based on the length of the certification.
Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

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

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

Participant-Direction of Services

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

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

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

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

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

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

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

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

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

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

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

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

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

8. Opportunities for Participant-Direction

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

X	The state does not offer opportunity for participant-employer authority.

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

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

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

Quality Improvement Strategy

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

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(Agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *(Analysis and Aggregation)*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	SP-1 Number and percent of service plans that accurately address all the member's assessed needs, including at a minimum, health and safety risk factors, and personal goals. Numerator: Number of service plans that accurately address all the member's assessed needs, including at a minimum, health and safety risk factors, and personal goals Denominator: Total number of reviewed service plans	Member service plans are reviewed at a 95% confidence level with +/- 5% margin of error on a three-year cycle. Data is inductively analyzed and reported to the state.	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is Collected Monthly and Quarterly	The MCO ensures that the Case Manager, Community-based Case Manager, or Integrated Health Home Care Coordinator has addressed the member's health and safety needs in the member's service or treatment plan. The Medical Services Unit completes a quality assurance desk review of member service plans within 10 days of receipt. The Medical Services Unit sends review results, notification of any deficiency, and expectations for remediation to Contracted Entity (Including MCOs) within 2 business days of completing the review. The Contracted Entity (Including MCOs) addresses any deficiencies with the provider, Case Manager, or Integrated Health Home and target training and technical assistance to those	Data is Aggregated and Analyzed Continuously and Ongoing

					deficiencies. General methods for problem correction at a systemic level include informational letters, provider training, and collaboration with stakeholders and changes in policy.	

	SP-2 Number and percent of members who responded "Yes" on the HCBS IPES survey to the question, "If your needs have changed, did your services change to meet your needs?" Numerator: Number of members who responded "Yes" on the HCBS IPES survey to the question, "If your needs have changed, did your services change to meet your needs?" Denominator: Total number of members who answered the question "If your needs have changed, did your services change to meet your needs?" on the HCBS IPES survey.	IPES Surveys are reviewed at a 95% confidence level with +/- 5% margin of error on a three-year cycle. Data is inductively analyzed and reported to the state.	Contracted Entity (Including MCOs)	Data is Collected Monthly and Quarterly	The MCO ensures that the Case Manager, Community-based Case Manager, or Integrated Health Home Care Coordinator has addressed the member's changing needs in the member's service or treatment plan and that services change as necessary to meet those needs. The Medical Services Unit completes a quality assurance desk review of member service plans within 10 days of receipt. The Medical Services Unit sends review results, notification of any deficiency, and expectations for remediation to Contracted Entity (Including MCOs) within 2 business days of completing the review. The Contracted Entity (Including MCOs) addresses any deficiencies with the provider, Case Manager, or Integrated Health Home and target training and technical assistance to those deficiencies. General methods for problem correction at a systemic level include informational letters, provider training, and collaboration with stakeholders and changes in policy.	Data is Aggregated and Analyzed Quarterly

	SP-3: Number and percent of service plans which are updated on or before the member's annual due date. Numerator: Number of service plans which were updated on or before the member's annual due date; Denominator: Number of service plans due for annual update that were reviewed.	Member service plans are reviewed at a 95% confidence level with +/- 5% margin of error on a three-year cycle. Data is inductively analyzed and reported to the state.	Contracted Entity (Including MCOs)	Data is Collected Monthly and Quarterly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly

	SP-4 Number and percent of members whose services were delivered according to the service plan, including type, scope, amount, duration, and frequency specified in the plan. Numerator: Number of members whose services were delivered according to the service plan, including type, scope, amount, duration, and frequency specified in the plan. Denominator: Total number of member's service plans reviewed	Member service plans are reviewed at a 95% confidence level +/- 5% margin of error on a three-year cycle. Data is inductively analyzed and reported to the state.	Contracted Entity (Including MCOs)	Data is Collected Monthly and Quarterly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly

	SP-5: Number and percent of members from the HCBS IPES who responded that they had a choice of services. Numerator: Number of HCBS IPES respondents who responded that they had a choice of services. Denominator: Total number of HCBS IPES respondents that answered the question asking if they had a choice of services.	IPES Surveys are reviewed at a 95% with +/- 5% margin of error confidence level on a three-year cycle. Data is inductively analyzed and reported to the state.	Contracted Entity (Including MCOs)	Data is Collected Monthly and Quarterly	See SP-2 Above	Data is Aggregated and Analyzed Quarterly

	SP-6: Number and percent of service plans from the HCBS QA survey review that indicated the member had a choice of providers NUMERATOR: Number of service plans reviewed which demonstrate choice of HCBS service providers DENOMINATOR: Total number of service plans reviewed	Member service plans are reviewed at a 95% confidence level with +/- 5% margin of error on a three-year cycle. Data is inductively analyzed and reported to the state.	Contracted Entity (Including MCOs)	Data is Collected Monthly	See SP-1 Above	Data is Aggregated and Analyzed Quarterly
Providers meet required qualifications.	QP-1: Number and percent of licensed or certified Habilitation providers verified against the appropriate licensing or certification standards prior to furnishing services. NUMERATOR: Number of licensed or certified Habilitation providers	Sampling Size: 100%	Contracted Entity (Including MCOs)	Data is Collected Monthly	Contracted Entities (Including MCOs) manage the provider networks and do not enroll providers who cannot meet the required qualifications. If it is discovered by the Provider Services unit or MCO during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, they are required to correct the deficiency prior to enrollment or reenrollment	Data is Aggregated and Analyzed Quarterly

	verified against the appropriate licensing or certification standards prior to furnishing services Note: The entire population is captured in this measure. All providers new and current will be evaluated during this process. DENOMINATOR: Number of licensed or certified Habilitation providers				approval. Until they make these corrections, they are ineligible to provide services to members. If it is discovered during HCBS Quality Oversight Unit review that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated is noncompliance persists. General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders, and changes in policy.	
	QP-2: Number and percent of reviewed HCBS Habilitation providers that met training requirements as outlined in State regulations. NUMERATOR: Number of reviewed HCBS Habilitation providers that met training requirements as outlined in State	Sample Size: 100%	Contracted Entity (Including MCOs)	Data is Collected monthly and quarterly	See QP-1 Above	Data is Aggregated and Analyzed Quarterly

	regulations. DENOMINATOR: Total number of HCBS Habilitation providers that had a certification or periodic quality assurance review.					
	QP-3: Number and percent of non-licensed/ noncertified providers that met Habilitation requirements prior to direct service delivery NUMERATOR: Number of non-licensed/noncertified providers who met Habilitation requirements prior to service delivery DENOMINATOR: Number of non-licensed/noncertified enrolled providers	Sampling Size: 100%	Contracted Entity (Including MCOs)	Data is Collected monthly and quarterly	See QP-1 Above	Data is Aggregated and Analyzed Quarterly

Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).	SR-1: Number and percent of service plans which indicate that the member resides in a setting that meets the HCB setting requirements. NUMERATOR: Number of service plans reviewed which indicate that the member resides in a setting that meets the HCB setting requirements. DENOMINATOR: The number of service plans reviewed	Member service plans are reviewed annually, and more frequently as member needs require, at a 95% confidence level with +/- 5% margin of error on a three-year cycle.	Contracted Entity (Including MCOs)	Data is Collected Continuously and Ongoing	Contracted Entities (Including MCOs) ensure that Case Managers or Integrated Health Home Care Coordinators have addressed the member's health and safety risks during service authorization. The Iowa Medicaid Medical Services Unit completes the QA Service Plan Desk Review within 10 days of receipt of the information from the member's HCB service provider(s) and the Case Manager or IHH Care Coordinator. The Iowa Medicaid Medical Services Unit will send the review results to the MCO and the Case Manager or Integrated Health Home Coordinator within 2 business days of completing the review.	Data is Aggregated and Analyzed Quarterly
	SR-2: Number and percent of service plans which indicate that the member is receiving services in a setting that meets the HCB setting requirements. NUMERATOR:	Member service plans are reviewed annually, and more frequently as member needs require, at a 95% confidence level with +/- 5% margin of error on a three-year cycle.	Contracted Entity (Including MCOs)	Data is Collected Continuously and Ongoing	Contracted Entities (Including MCOs) ensure that Case Managers or Integrated Health Home Care Coordinators have addressed the member's health and safety risks during service authorization. The Iowa Medicaid Medical Services Unit completes the QA Service Plan Desk Review within 10 days of	Data is Aggregated and Analyzed Quarterly

	Number of service plans reviewed which indicate that the member is receiving services in a setting that meets the HCB setting requirements DENOMINATOR: The total number of service plans reviewed				receipt of the information from the member's HCB service provider(s) and the Case Manager or IHH Care Coordinator. The Iowa Medicaid Medical Services Unit will send the review results to the MCO and the Case Manager or Integrated Health Home Coordinator within 2 business days of completing the review.	
The SMA retains authority and responsibility for program operations and oversight.	AA-1: Number and percent of required MCO HCBS PM Quarterly reports that are submitted timely NUMERATOR: Number of MCO HCBS PM Quarterly reports submitted timely. DENOMINATOR: Total number of MCO HCBS PM Quarterly reports due in a calendar quarter.	Contracted Entity and MCO performance monitoring. Sampling: 100% Review	Contracted Entity (Including MCOs)	Data is Collected Monthly	Each operating agency within Iowa Medicaid is assigned state staff to serve as a contract manager. This position oversees the quality and timeliness of monthly scorecards and quarterly contract reports. Further, Iowa Medicaid holds a monthly manager meeting in which the account managers of each contracted unit present the operational and performance issues discovered and remediated within the past month. This allows all state staff to collectively sustain transparent administrative oversight. If the contract manager, or policy staff, discovers and documents a repeated deficiency in	Data is Aggregated and Analyzed Quarterly

					performance of the contracted unit, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of invoiced payment compensation.	
	AA-2: Number and percent of months in a calendar quarter that each MCO reported all HCBS PM data measures NUMERATOR: Number of months each MCO entered all required HCBS PM data; Denominator = Total number of reportable HCBS PM months in a calendar quarter.	Contracted Entity performance monitoring. Sampling: 100% Review	Contracted Entity	Data is Collected Quarterly	See AA-1 Above	Data is Aggregated and Analyzed Quarterly

The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	FA-1: Number and percent of FFS reviewed paid claims supported by provider documentation NUMERATOR: Number of FFS reviewed paid claims supported by provider documentation DENOMINATOR: Number of managed care provider claims reviewed	Program Integrity Unit Sampling: 95% confidence level with +/- 5% margin of error	Contracted Entity (Including MCOs)	Data is Collected Quarterly	Program Integrity reviews claims and evaluates whether there was supporting documentation to validate the claim. The Managed Care Organizations will evaluate their claims. When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped, and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments, require screening of all claims, referral to MFCU, or provider suspension. The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a monthly and quarterly basis.	Data is Aggregated and Analyzed Quarterly
	FA-2: Number and percent of clean claims that are paid by the managed care organizations within the timeframes	The Program Integrity (PI) unit Sampling: 95% confidence level with +/- 5% margin of	Contracted Entity (Including MCOs)	Data is Collected Quarterly	See FA-1 Above	Data is Aggregated and Analyzed Quarterly

	specified in the contract NUMERATOR: Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract DENOMINATOR: Total number of managed care provider claims reviewed	error				
	FA-3: Number and percent of claims that are reimbursed according to the Iowa Administrative Code-approved rate methodology for the services provided NUMERATOR: Number of paid claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for the	Program Integrity Unit SAMPLING: 100% Sample	Contracted Entity (Including MCOs)	Data is Collected Monthly	See FA-1 Above	Data is Aggregated and Analyzed Quarterly

	services provided DENOMINATOR: Number of paid claims					
	FA-4 Number and percent of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology and rate through the CMS certified MMIS NUMERATOR: Number of Capitation payments made to the MCOs at the approved rate methodology and rates through the CMS certified MMIS DENOMINATOR: Number of capitation payments made through the CMS certified MMIS	HCBS QIO SAMPLING: 100% Sample	Contracted Entity	Data is Collected Monthly	Iowa Medicaid Data Warehouse will pull data quarterly. Core will review the capitation payments on a monthly basis and ensure that the capitation amount paid is the approved CMS rate.	Data is aggregated and analyzed Quarterly

The state identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	HW-1: Number and percent of IAC-defined major critical incidents identified by the HCBS QIO as requiring follow-up escalation that were investigated as required NUMERATOR: Number of IAC-defined major critical incidents as identified by the HCBS QIO requiring follow-up escalation that were investigated as required; DENOMINATOR: Number of IAC-defined major critical incidents identified by the HCBS QIO requiring follow-up escalation.	MCO reporting and IMPA reports are generated by the HCBS Incident Reporting Specialist. This data on incidents is inductively analyzed at 100%.	Contracted Entity (Including MCOs)	Data is Collected Monthly, Quarterly, and Annually	The HCBS Incident Reporting Specialist analyzes data for individual and systemic issues. Individual issues require communication with the service worker, case manager, IHH coordinator or MCO community-based case manager to document all efforts to remediate risk or concern. A follow-up escalation for an FFS or MCO member requires an FFS/MCO request to the provider for additional information if warranted by a CIR submission. If the additional research demonstrates a deficiency within provider policy or procedure, the FFS or MCO will open a targeted review to assist in remediation If these efforts are not successful, the IR Specialist continues efforts to communicate with the service worker, case manager, IHH coordinator or MCO community-based case manager their supervisor, and protective services when necessary. All remediation efforts of this type are documented in the monthly and quarterly reports. The HCBS Specialists conducting interviews conduct individual remediation to flagged	Data is Aggregated and Analyzed Quarterly

					questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the service worker, case manager, IHH coordinator or MCO community-based case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders, and changes in policy. In addition, Contracted Entities (including MCOs) initiate a quality-of-care review of all known adverse incidents involving a member who is receiving services or having care managed by the contractor. When contractor staff becomes aware of an adverse incident the incident is communicated to medical directors and/or compliance staff. If deemed high-risk the compliance staff requests recourse from the	

					service provider and the incident is communicated to clinical leadership within 24 hours. Within 5 business days the contractor's legal department is required to review the case to determine if an incident review is required. A full audit of the incident must be completed within 15 days. The contractor must then submit the incident report data to the Iowa Medicaid, HCBS Quality Assurance Manager. The Iowa Medicaid HCBS Quality Assurance Committee will review the data quarterly and address any trends requiring additional follow-up with the contractor.	
	HW-2: Number and percent of CIRs including alleged abuse, neglect, exploitation, or unexplained death that the HCBS QIO identified as followed up on as required NUMERATOR: Number of CIRs including a report of alleged abuse,	MCO reporting and IMPA reports are generated by the HCBS Incident Reporting Specialist SAMPLING: 100%	Contracted Entity (Including MCOs)	Data is Collected Monthly, Quarterly, and Annually	See HW-1 Above	Data is Aggregated and Analyzed Quarterly

	neglect, exploitation, or unexplained death that the HCBS QIO identified as followed up on as required DENOMINATOR: Total number of CIRs that identified a reportable event of abuse, neglect, exploitation, and/or unexplained death					
	HW-3: Number and percent of members who received information on how to report abuse, neglect, exploitation and unexplained deaths NUMERATOR: Number of members service plans that indicate the members received information on how to report abuse, neglect, exploitation and unexplained deaths DENOMINATOR: Total number of	MCO reporting and IMPA reports are generated by the HCBS Incident Reporting Specialist Sampling: 100%	Contracted Entity (Including MCOs)	Data is Collected Monthly, Quarterly, and Annually	See HW-1 Above	Data is Aggregated and Analyzed Quarterly

	member service plans reviewed					
	HW-4: Number and percent of unresolved critical incidents that resulted in a targeted review that were appropriately resolved. NUMERATOR: Number of unresolved critical incidents that resulted in a targeted review that were appropriately resolved; DENOMINATOR: Total number of unresolved critical incidents that resulted in a targeted review.	MCO reporting and IMPA reports are generated by the HCBS Incident Reporting Specialist Sampling size: 100%	Contracted Entity (Including MCOs)	Data is Collected Monthly, Quarterly, and Annually	See HW-1 Above	Data is Aggregated and Analyzed Quarterly
	HW-5: Number and percent of critical incidents where root cause was identified NUMERATOR:	MCO reporting and IMPA reports are generated by the HCBS Incident Reporting Specialist	Contracted Entity (Including MCOs)	Data is Collected Monthly, Quarterly, and Annually	See HW-1 Above	Data is Aggregated and Analyzed Quarterly

	Number of critical incidents where root cause was identified DENOMINATOR: Total number of critical incident reports	Sampling size: 100%				
	HW-6: Number and percent of reviewed providers with policies for restrictive measures that are consistent with State and Federal policy and rules, and were followed as written NUMERATOR: Number of providers reviewed that have policies for restrictive measures that are consistent with State and Federal policy and rules, and followed as written DENOMINATOR: Total number of	HCBS QIO Onsite QA review process Sampling size: 95% confidence level with +/- 5% margin of error	Contracted Entity	Data is Collected Monthly, Quarterly, and Annually	A representative sample of member case manager/care coordinators service plans, provider service plans and documentation will be reviewed to identify the existence of Behavioral Support Plans for any restrictive interventions Policies for restrictive measures include restraint, seclusion, restrictive interventions, behavioral interventions and behavioral management plans. The Quality Assurance Review ensures that providers are following State and Federal rules and regulations. In areas where a provider is determined to not be following State and Federal rules and Regulations a corrective action plan is issued to bring them into compliance. Providers issued a Probational Certification may be counted	Data is Aggregated and Analyzed Quarterly

	providers reviewed				twice, depending upon review cycles.	
	HW-7: Number and percent of Quality Assurance reviews completed where the provider did not receive a corrective action plan. NUMERATOR: Number of Quality Assurance reviews completed where the provider did not receive a corrective action plan DENOMINATOR: Total number of provider Quality Assurance Reviews completed	HCBS QIO Provider Quality Assurance Reviews Sampling size 100%	Contracted Entity	Data is Collected Monthly	The Quality Assurance Review ensures that providers are following State and Federal rules and regulations. In areas where a provider is determined to not be following State and Federal rules and Regulations a corrective action plan is issued to bring them into compliance. Providers issued a Probational Certification may be counted twice, depending upon review cycles.	Data is Aggregated and Analyzed Quarterly
	HW-8 Number and percent of emergency room visits that meet the definition of a CI where a CIR was submitted. NUMERATOR: Number emergency room visits, that	HCBS QIO IMPA reports are generated by the HCBS Incident Reporting Specialist	Contracted Entity	Data is Collected Monthly	HCBS QIO Provider Quality Assurance Reviews	Data is Aggregated and Analyzed Quarterly

	meet the definition of a CI, where a CIR was submitted; DENOMINATOR: Total number of emergency room visits meeting the definition of CI.					
	HW-9 Number and percentage of Habilitation members who received care from a primary care physician in the last 12 months. NUMERATOR: Number of Habilitation members who received care from a primary care physician in the last 12 months; DENOMINATOR: Number of Habilitation members reviewed.	HCBS QIO IMPA reports are generated by the HCBS Incident Reporting Specialist	Contracted Entity	Data is Collected Monthly	HCBS QIO Provider Quality Assurance Reviews	Data is Aggregated and Analyzed Quarterly
An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants	LC-1: Number and percent of new referrals who had an evaluation indicating the individual 1915(i) eligible prior to	IoWANS and MQUIDS MCO – PCP history system	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is collected quarterly	The data informing this performance measure is pulled from IoWANS and MCO data. The state's Medical Services Unit performs internal quality reviews of initial and annual	Data is Aggregated and Analyzed Quarterly

for whom there is reasonable indication that 1915(i) services may be needed in the future.	receipt of services. NUMERATOR: Number of completed needs based eligibility determinations (initial) DENOMINATOR: Total number of referrals for needs-based eligibility determination (initial)	Sample Size: 95% confidence level with +/- 5% margin of error			1915(i) eligibility determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred the unit recommends that the service worker take steps to initiate a new 1915(i) eligibility determination through communication with the member and physician. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.	
The 1915(i) eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.	LC-2: Number and percent of members who have a 1915(i)-eligibility determination completed within 12 months of their initial evaluation or last annual reevaluation. NUMERATOR: Number of completed 1915(i)-eligibility determinations DENOMINATOR: Total number of	FFS – IoWANS and MQUIDS MCO – PCP history system Sample Size: 95% confidence level with +/- 5% margin of error	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is collected quarterly	See LC-1 above.	Data is Aggregated and Analyzed Quarterly

	referrals for needs-based eligibility review					
The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.	LC-3: Number and percent of initial needs-based eligibility decisions that were accurately determined by applying the approved needs-based eligibility criterion using standard operating procedures NUMERATOR: Number of needs-based eligibility decisions that were accurately determined by applying the correct criteria DENOMINATOR: Total number of reviewed needs-based eligibility determinations.	Sampling Size: 95% confidence level with +/- 5% margin of error	State Medicaid Agency & Contracted Entity (Including MCOs	Data is collected quarterly	See LC-1 above.	Data is Aggregated and Analyzed Quarterly

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

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

			test/pilot changes that are suggested and developed. Informational letters are sent out to all relevant parties prior to implementation with contact information of key staff involved. This workflow is documented in logs and in informational letters found within the HHS 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. Based on contract oversight and performance measure implementation, Iowa Medicaid holds weekly policy staff and long-term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff. Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance group gathers monthly to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. Data from QA/QI activities are also

			presented to the HCBS QA/AI Committee on a quarterly basis. The QA/QI Committee reviews the data makes recommendations for changes in policy to the Iowa Medicaid Policy staff and Bureau Chief. The Committee also uses this information to direct HCBS Provider Quality Oversight Specialists to provide training, technical assistance, or other activity. The Committee monitors training and technical assistance activities to assure consistent implementation statewide. The Committee also directs workgroups on specific activities of quality improvement and other workgroups are activated as needed. The Committee is made up of certain HCBS Provider Quality Oversight staff and supervisors, and Iowa Medicaid Policy staff. Minutes are taken at each of the meetings, which show evidence that analysis of data is completed and recommendations for remediation and system improvements are made. Finally, Iowa Medicaid analyzes general system performance through the management of contract performance benchmarks, IoWANS reports, and Medicaid Value Management reports and then works with contractors, providers, and other agencies regarding specific issues. HCBS Annual Reports are sent to the Iowa Association of Community Care Providers. Reports are also available to

			agencies, providers, participants, families, and other interested parties upon request.
	All service providers, case managers, 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 HHS upon request. Providers, case managers, and MCO CBCMs must also ensure cooperation in providing pertinent information regarding incidents as requested by HHS. 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 1915(i) Habilitation Program and all other incidents required for licensure of programs through the Department of Inspections and Appeals. Per Chapter 441 Iowa Administrative Code 77.41(12), …"major incidents" are defined as an occurrence involving a member that is enrolled in an HCBS waiver, targeted case management, or habilitation services, and that: (1) results in a physical injury to or by the member 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 member; (4) requires the	Data is collected ongoing	HHS has oversight for monitoring incidents that affect all Habilitation participants. As part of the quality assurance policies and procedures for HCBS Habilitation 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. The HCBS QIO reviews all critical incident reports as soon as they are reported to HHS. All critical incidents are tracked in a critical incident database that tracks the date of the event, the specific HCBS program 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 Protective Services (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 with in twenty working

	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 member's location being unknown by provider staff who are assigned protective oversight. All major incidents must be reported by the end of the next calendar day after the incident has occurred using the Iowa Medicaid Portal Access (IMPA) System. Suspected abuse or neglect may be reported to the statewide abuse reporting hotline operated by HHS. 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.		days of receipt of report. For other non-jeopardy incidents, a review is initiated within twenty days. The HCBS QIO 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.

	- 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 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 member who is enrolled in an HCBS waiver, targeted case management, or habilitation services, and 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 BLTSS, 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. MCOs are also required to develop and implement a critical incident management system in accordance with HHS 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 QIO 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. MCOs are responsible for developing and implementing critical incident management systems in accordance with the HHS requirements. Specifically, MCOs must maintain policies and procedures, subject to HHS 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 77.41(12)c. 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:		

	a. The staff member's supervisor. b. 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 a guardian, if any, is always required. c. 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 in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either: a. By direct data entry into the Iowa Medicaid Provider Access System, or b. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form. (3) The following information shall be reported:		

	a. The name of the member involved. b. The date and time the incident occurred. c. A description of the incident. d. 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 individuals who were present must be maintained by the use of initials or other means e. The action that the provider staff took to manage the incident. f. The resolution of or follow-up to the incident. g. 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 HHS 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.		
In accordance with 42 CFR 438.202, the State maintains a written strategy for assessing and improving the quality of services offered by MCOs including, but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries.	MCOs must comply with the standards established by the State and must provide all information and reporting necessary for the State to carry out its obligations for the State quality strategy. Iowa Medicaid performs an annual review of each MCO. This is generally conducted at the time of the annual External Quality Review (EQR) and includes a determination of contract compliance, including that for fraud and abuse reporting and training. EQR is performed as federally required, and committee reports are reviewed during an annual visit. The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the State and authenticated as it can be used during onsite visits and through regular reports.	Reviews are Conducted Annually	The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the state and authenticated as it can be used during onsite visits and through regular reports. The Medical Services Unit contractor conducts an annual EQR of each managed care entity to ensure that they are following the outlined QA/QI plan. In addition to developing QM/QI programs that include regular, ongoing assessment of services provided to Medicaid beneficiaries, MCOs must maintain a QM/QI Committee that includes medical, behavioral health, and long-term care staff, and network providers. This committee is responsible for analyzing and evaluating the result of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action, and ensuring appropriate follow-up. This committee is also responsible for reviewing and approving the MCOs' QM/QI program description, annual evaluation, and associated work plan prior to submission to HHS.

All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas.	MCO QM/QI programs must have objectives that are measurable, realistic, and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the goal of improving member health outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 subpart D and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program, and the State Medical Services conducts an annual EQR of each MCO to ensure that they are following the outlined QA/QI plan.	Reviews are Conducted Annually	The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the state an authenticated as it can be used during onsite visits and through regular reports.
MCOs must attain and maintain accreditation from the National Committee for Quality Assurance (NCQA) or URAC.	If not already accredited, the MCO must demonstrate it has initiated the accreditation process as of the MCO's contract effective date. The MCO must achieve accreditation at the earliest date allowed by NCQA or URAC. Accreditation must be maintained throughout the life of the MCO's contract at no additional cost to the State. When accreditation standards conflict with the standards set forth in the MCO's contract, the contract prevails unless the accreditation standard is more stringent.	Reviews are Conducted Every Three Years	NCQA and URAC publicly report summarized plan performance, as well as accreditation type, accreditation expiration date, date of next review and accreditation status for all NCQA accredited plans in a report card available on the NCQA website. This report card provides a summary of overall plan performance on several standards and measures through an accreditation start rating comprised of five categories (access and service, qualified providers, staying health, getting better, living with illness).

	MCOs must meet the requirements of 42 CFR 438 subpart D and the standards of the credentialing body by which the MCO is credentialed.		

STATE PLAN UNDER TITLE XIX 0F THE SOCIAL SECURITY ACT

State/Territory: IOWA

STANDARDS AND METHODS TO ASSURE HIGH QUALITY CARE

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

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

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

3. Procedures exist to assure that workers in local Health and Human Services offices can assist people in securing necessary medical services.

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

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

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

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