Health Home Provider Quality Self-Assessment

Instructions

This self-assessment addresses the requirement in 77.47(5)f. Policies and procedures. The health home must have policies and processes in place to ensure compliance with federal and state requirements, including but not limited to statutes, rules and regulations, and sub-regulatory guidance. The health home must maintain documentation of its policies and processes and make those policies and processes readily available to any state or federal officials upon request.

The Health Home Quality Self-Assessment form is a fillable PDF and must remain in that format upon submission. It includes an electronic signature attesting that the information submitted is true, accurate, complete, and verifiable. Organizations are responsible for ensuring signatory authority. Each organization is required to submit to the state, an acceptable self-assessment by XXXX each year. Incomplete or inaccurate self-assessments will not be accepted. Failure to submit a complete and accurate self-assessment by XXXX, will result in a referral to Iowa Medicaid's Program Integrity Unit for appropriate action, which may include sanctions and disenrollment from Iowa Medicaid. Below is a brief explanation of each section of the Health Home Provider Quality Self-Assessment For full instructions, troubleshooting tips, and training on the Provider Quality Self-Assessment, please click here. When assessment is completed, the organization will upload documentation identified in the "Evidence as Submitted by the Health Home" sections below by using the same methods used to upload record review documentation.

I. Organizational Details. Identifies the organization submitting the forms.

II. Self-Assessment Questionnaire. Provides an outline of all basic standards required by law, rule, state plan amendment, industry standards, or best practice. For your reference, resource links have been included with each standard. You should read each standard, consider your organization's current situation, and select the most appropriate response. Selecting "Met" means your organization meets the standards. You may meet the standard because you are required to by law or rule, organization policy or because your organization does so as best practice or because you are required to by another oversight entity outside of Iowa Medicaid. Selecting "Not Met" means your organization does not meet the standard in its entirety but is required to by law, rule, or organization policy or the standard is otherwise necessary for the services your organization is enrolled to provide. If you select Not Met, you must provide a response (plan) in the designated box describing your remediation plan to meet the standard(s). A plan is sometimes also known as a "remediation plan", corrective action plan, or "CAP". It describes what the organization will do correct

the problem with specific timelines for achieving compliance. There is one standard has an option of "NA" as not all Health Homes serve members that have Children's Mental Health Waiver. For this standard, adult only practices are the only ones that are allowed to select "NA". Selecting "NA" means the standard is not required by law, rule, or organization policy and is not otherwise necessary for the services your organization is enrolled to provided. At the end of each topic "Health Home Description of Process", there is an opportunity for your organization to highlight how your organization meets or exceeds the requirements.

III. Guarantee of Accuracy. Identifies your organization's pertinent certifications, accreditations, and licensures. Typically, you would list certifications, accreditations, and licensures that make your organization eligible to enroll for and provide Health Home services. The Guarantee of Accuracy also requires your organization to attest that the information and responses are true, accurate, complete, and verifiable.

Questions should be directed to the Health Home email healthhomes@dhs.state.ia.us

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Organizational Details

Please identify your parent agency by providing the following information using the text entry fields below.

Employer ID Number (EIN) (9 Digits)					
National Provider Number (NPI)					
Population Served ☐ Adult ☐ Child ☐ Both					
Organizational Name					
Mailing Address					
City		**State**		**Zip**	
Physical Address					
City		**State**		**Zip**	
Counties Served					
Executive Director/Administrator				**Title**	
Email				**Telephone**	
Self-Assessment Contact				**Title**	
Email				**Telephone**	
Organization Website					

Self-Assessment Questionnaire

Standard: Conditions of Participation		
Provider Enrollment Requirement	**Documentation**	**Met/Not Met**
"*Integrated health home*" means a health home that meets the criteria in 441—subrule 77.47(3). Integrated health home provider qualifications. *a.* An integrated health home must be one of the following: (1) Community mental health center accredited under 441—Chapter 24. (2) Licensed mental health service provider. (3) Licensed residential group care setting. (4) Licensed psychiatric medical institution for children (PMIC). (5) Provider accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide behavioral health services. (6) Provider accredited by the Council on Accreditation for behavioral health or child, youth, and family services. (7) Provider accredited by the Joint Commission for behavioral health care services. (8) Provider accredited under 441—Chapter 24 to deliver services to persons with mental illness. *b.* An integrated health home may include multiple sites when those sites are identified as a single organization or medical group that shares policies, procedures, and electronic systems across all of the single organization's or medical group's practice sites. *c.* An integrated health home must complete a self-assessment when enrolling as a new health home and annually thereafter. *d.* An integrated health home must meet the requirements, qualifications, and standards outlined in the integrated health home state plan amendment. *e.* An integrated health home must participate in monthly, quarterly, and annual outcomes data collection and reporting. *f.* At a minimum, an integrated health home must fill the following roles: (1) If serving adults: 1. Nurse care manager. The integrated health home must have a nurse care manager who is a registered nurse or has a bachelor of science in nursing with an active Iowa nursing license in accordance with rule 655—3.3(17A,147,152,272C). 2. Care coordinator. The integrated health home must have a care coordinator who has a bachelor of science in social work or a bachelor of science or bachelor of arts degree in a related field. 3. Trained peer support specialist. The integrated health home must have a peer support specialist	**Required Evidence:** • Documentation that substantiates the provider meets the qualifications to be a Health Home. • Process that outlines how the Health Home submits the documentation prior to expiration or notifies the state if it will expire prior to receiving updated accreditation. • Process for tracking an keeping up to date credentialing of staff. **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: Conditions of Participation		
Provider Enrollment Requirement	**Documentation**	**Met/Not Met**
who has completed a department-recognized training program and passed the competency examination within six months of hire. (2) If serving children: 1. Nurse care manager. The integrated health home must have a nurse care manager who is a registered nurse or has a bachelor of science in nursing with an active Iowa nursing license in accordance with rule 655—3.3(17A,147,152,272C). 2. Care coordinator. The integrated health home must have a care coordinator who has a bachelor of science in social work or a bachelor of science or bachelor of arts degree in a related field. 3. Family peer support specialist. The integrated health home must have a family peer support specialist who has completed a department-recognized training program and passed the competency examination within six months of hire. 441—24 441—77.47 441—78.53 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
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Standard: Documentation		
Requirement: Medical Records	**Documentation**	**Met/Not Met**
79.3(2) Medical (clinical) records. A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing. a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:**	☐ Met ☐ Not Met

Standard: Documentation		
Requirement: Medical Records	**Documentation**	**Met/Not Met**
(1) The provision of each service and each activity billed to the program; and (2) First and last name of the member receiving the service. b. Purpose. The medical record shall provide evidence that the service provided is: (1) Medically necessary; (2) Consistent with the diagnosis of the member's condition; and (3) Consistent with professionally recognized standards of care. c. Components. (1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name. (2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2)"d." The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity: 1. The member's complaint, symptoms, and diagnosis. 2. The member's medical or social history. 3. Examination findings. 4. Diagnostic test reports, laboratory test results, or X-ray reports. 5. Goals or needs identified in the member's plan of care. 6. Physician orders and any prior authorizations required for Medicaid payment. 7. Medication records, pharmacy records for prescriptions, or providers' orders. 8. Related professional consultation reports. 9. Progress or status notes for the services or activities provided. 10. All forms required by the department as a condition of payment for the services provided. 11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.	•	

Standard: Documentation		
Requirement: Medical Records	**Documentation**	**Met/Not Met**
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative. 13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment. (3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided. Unless otherwise indicated below, the provider may document the services in any format so long as the documentation adequately substantiates the medical necessity and that the services were rendered. The service record shall include the following: 1. The specific procedures or treatments performed. 7. Narrative description of any incidents or illnesses or unusual or atypical occurrences that occur during service provision. 8. Any supplies dispensed as part of the service. 9. The first and last name and professional credentials, if any, of the person providing the service. 10. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity (4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis. d. Basis for service requirements for specific services. The health care provider should include all records and documentation that substantiate the services provided to the member and all information necessary to allow accurate adjudication of the claim. Additionally, documentation requirements must meet the professional standards pertaining to the service provided. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it) (33) Case management services, including HCBS case management services: 1. Notice of decision for service authorization. 2. Service notes or narratives. 3. Social history.		

Standard: Documentation		
Requirement: Medical Records	**Documentation**	**Met/Not Met**
4. Comprehensive service plan. 5. Reassessment of member needs. 6. Incident reports in accordance with 441—subrule 24.4(5). 7. Other service documentation as applicable. (40) Health home services: 1. Member's eligibility. 2. Comprehensive assessment. 3. Comprehensive care management plan for members receiving chronic condition health home services, or comprehensive person-centered care plan or service plan for members receiving integrated health home services. 4. Care coordination and health promotion plan. 5. Comprehensive transitional care plan, including appropriate follow-up, if relevant. 6. Continuity of care document. 7. Documentation of member and family support (including authorized representatives). 8. Documentation of referral to community and social support services, if relevant. 9. Service notes or narratives. 10. Other documentation as applicable, including as outlined in 441—subrule 78.53(5). e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement. (1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service. (2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable. (3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record. (4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted. 79.3(3) Maintenance requirement. The provider shall maintain records as required by this rule: a. During the time the member is receiving services from the provider. b. For a minimum of five years from the date when a claim for the service was submitted to the		

Standard: Documentation		
Requirement: Medical Records	**Documentation**	**Met/Not Met**
medical assistance program for payment. c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications. 441—24 441—77.47 441—78.53 441—79.3 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
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Standard: General Requirements		
Requirement: Payment	**Documentation**	**Met/Not Met**
78.53(6) Payment. a. Payment will be made for health home services when: (1) The member is eligible for Medicaid and enrolled in the health home for the month of service, and (2) The health home provides at least one of the six core health home services described in subrule 78.53(2) during the month. (3) The health home maintains the documentation outlined in subrule 78.53(5). b. A unit of service is one member month. c. The health home must report the informational-only code in addition to the billing procedure code and modifier for one or more of the core services provided to the member during the month on the claim for payment.	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: General Requirements		
Requirement: Payment	**Documentation**	**Met/Not Met**
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Standard: General Requirements		
Requirement: Whole Person Orientation	**Documentation**	**Met/Not Met**
Whole person orientation. The health home is responsible for providing whole person care. (1) The health home must provide or take responsibility for appropriately arranging care with other qualified professionals for all the member's health care needs. This includes care for all stages of life, including acute care, chronic care, preventive services, long-term care, and end-of-life care. (2) The health home must complete status reports to document the member's housing, legal status, employment status, education, custody, and other social determinants of health, as applicable. (3) The health home must implement a formal screening tool to assess behavioral health, including mental health and substance abuse treatment needs, along with physical health care needs. (4) The health home must work with the lead entity or Iowa Medicaid to develop capacity to receive members redirected from emergency departments, engage in planning transitions in care with area hospitals, and follow up on hospital discharges, including psychiatric medical institutions for children. (5) The health home must provide bidirectional and integrated primary care and behavioral health services through use of a contract, memoranda of agreement, or other written agreements approved by the department. (6) The health home must, at the time of enrollment and reenrollment, provide letters of support from at least one area hospital and two area primary care practices that agree to collaborate with the	**Required Evidence:** • Policies and processes • Contracts and agreements with qualified professionals • Sample status reports • Formal screening tools • Letters of support **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: General Requirements		
Requirement: Whole Person Orientation	**Documentation**	**Met/Not Met**
health home on care coordination and hospital and emergency department notification. (7) The health home must advocate in the community on behalf of health home members, as needed. (8) The health home must be responsible for preventing fragmentation or duplication of services provided to members. 441—77.47 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
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Standard: General Requirements		
Requirement: Coordinated Integrated Care	**Documentation**	**Met/Not Met**
b. Coordinated integrated care. The health home must provide coordinated integrated care. (1) The health home must ensure that the nurse care manager is responsible for oversight of the service, including assisting members with medication adherence, appointments, referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support or lifestyle modification, and behavior changes. (2) The health home must utilize member-level information, member profiles, and care coordination plans for high-risk individuals. (3) The health home must incorporate tools and evidence-based guidelines designed for identifying care opportunities across the age and diagnostic continuum, integrating clinical practices, and coordinating care with other providers. (4) The health home must conduct interventions as indicated based on the member's level of risk. (5) The health home must communicate with the member, authorized representative, and the member's family and caregivers in a culturally appropriate manner for the purposes of assessment of	**Required Evidence:** • Policies and processes • Tools and evidenced-based guidelines • Risk assessments • Behavior modification tools **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: General Requirements		
Requirement: Coordinated Integrated Care	**Documentation**	**Met/Not Met**
care decisions, including the identification of authorized representatives. (6) The health home must monitor, arrange, and evaluate appropriate evidence-based and evidence-informed preventive services. (7) The health home must coordinate or provide access to the following services: 1. Mental health. 2. Oral health. 3. Long-term care. 4. Chronic disease management. 5. Recovery services and social health services available in the community. 6. Behavior modification interventions aimed at supporting health management, including but not limited to obesity counseling, tobacco cessation, and health coaching. 7. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up. 8. Crisis services. (8) The health home must assess social, educational, housing, transportation, and vocational needs that may contribute to disease and present as barriers to self-management. (9) The health home must coordinate with community-based case managers, case managers, and service coordinators for members who receive service coordination activities. (10) The health home must maintain a system and written standards and protocols for tracking member referrals. 441—77.47 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
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Standard: General Requirements		
Requirement: Enhanced Access	**Documentation**	**Met/Not Met**
c. Enhanced access. The health home must provide enhanced access for members and member caregivers, including access to health home services 24 hours per day, seven days per week. The health home must use email, text messaging, patient portals and other technology to communicate with members based on the member's preferred method of communication. 441—77.47 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met
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Standard: General Requirements		
Requirement: Emphasis on Quality and Safety	**Documentation**	**Met/Not Met**
d. Emphasis on quality and safety. The health home must emphasize quality and safety in the delivery of health home services. (1) The health home must have an ongoing quality improvement plan to address gaps and identify opportunities for improvement. (2) The health home must participate in ongoing process improvement on clinical indicators and overall cost-effectiveness. (3) The health home must demonstrate continuing development of fundamental health home functionality through an assessment process applied by the department. (4) The health home must have strong, engaged organizational leadership that is personally committed to and capable of: 1. Leading the health home through the transformation process and sustaining transformed practice, and 2. Participating in learning activities including in-person sessions, webinars, and regularly scheduled	**Required Evidence:** • Policies and processes • Quality Improvement Plan • Patient registry • Certified electronic health record • Disease Management Programs **Evidence as Submitted by the Health Home:**	☐ Met ☐ Not Met

Standard: General Requirements		
Requirement: Emphasis on Quality and Safety	**Documentation**	**Met/Not Met**
meetings. (5) The health home must participate in or convene ad hoc or scheduled meetings with lead entities and the department to plan and discuss implementation of goals and objectives for practice transformation, with ongoing consideration of the unique practice needs for adult members with a serious mental illness and child members with a serious emotional disturbance and those members' families. (6) The health home must participate in Centers for Medicare and Medicaid Services (CMS)- and department-required evaluation activities. (7) The health home must submit information as requested by the department. (8) The health home must maintain compliance with all of the terms and conditions of the integrated health home or chronic condition health home provider agreement. (10) The health home must complete web-based member enrollment, disenrollment, members' consent to release of information, and health risk questionnaires for all members. (12) The health home must implement state-required disease management programs based on population-specific disease burdens. The health home may choose to identify and operate additional disease management programs at any time. 6. Identifies opportunities for improvement, if applicable. 441—77.47 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment	•	
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Standard: General Requirements		
Requirement: Health Information Technology	**Documentation**	**Met/Not Met**
(9) The health home must use an interoperable patient registry and certified electronic health record within a timeline approved by the lead entity or the department to input clinical information, track and measure care of members, automate care reminders, and produce exception reports for care planning. (11) The Health Home shall use a certified electronic health record to support clinical decision making within the practice workflow and establish a plan to meaningfully use health information in accordance with the federal law. Health Information Technology (HIT) will link services, provide feedback, and facilitate communication among team members. Electronic sharing of health data among Lead Entities, behavioral and physical health providers in a HIPAA compliant manner enables tight coordination with the broader physical health delivery system. Online profiles are able to include medical, behavioral and pharmacy history. As a part of the minimum requirements of an eligible provider to operate as a Health Home, the following relate to HIT: ▪ Demonstrate use of a population management tool (patient registry) and the ability to evaluate results and implement interventions that improve outcomes over time ▪ Demonstrate evidence of acquisition, instillation, and adoption of an EHR, system and establish a plan to meaningfully use health information in accordance with federal law ▪ Provide 24/7 access to the care team that includes but is not limited to a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations. ▪ Utilize email, text, messaging, patient portals and other technology as available to communicate with other providers. The use of HIT is a means of facilitating these processes that include the following components of care: ▪ Mental health/behavioral health ▪ Oral health ▪ Long-term care ▪ Chronic disease management ▪ Recovery services and social health services available in the community ▪ Behavior modification interventions aimed at supporting health management (e.g., obesity counseling and tobacco cessation, health coaching)	**Required Evidence:** • Policies and processes • Electronic Health Record • Patient Registry **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: General Requirements		
Requirement: Health Information Technology	**Documentation**	**Met/Not Met**
▪ Comprehensive transitional care from inpatient to other settings, including appropriate follow-up The Health Home shall use an interoperable patient registry and certified electronic health record within a timeline approved by the Lead Entity or the department, to input clinical information to track and measure care of members, automate care reminders, and produce exception reports for care planning. 441—77.47 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
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Standard: General Requirements		
Requirement: Report on Quality Measures	**Documentation**	**Met/Not Met**
g. Report on quality measures. A health home must collect and report quality data to the lead entity and the department as specified by the department. 441—77.47 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met
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Standard: General Requirements		
Requirement: Member Eligibility	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) a. Eligibility. Eligibility documentation includes but is not limited to the following: (1) How the member presented to the health home, including the referral. (2) Identified needs and plan to assess for eligibility. (3) Documentation that the member is eligible for health home services. If a member is not eligible, the health home must document the plan to support the member. (4) Qualifying diagnosis that makes the member eligible for health home services. (5) Member agreement and understanding of the program. (6) Enrollment request. (7) Enrollment with the health home. (8) Plan to complete the comprehensive assessment. (9) Documentation of continued eligibility, reviewed annually and maintained in the member's service record To be eligible for Health Home Services, the member must have a serious mental illness or serious emotional disturbance. Eligible members are identified though a referral from the department, Lead Entity, primary care provider, hospital, other providers, member, or the member's authorized representative. The Health Home confirms eligibility for Health Home Services by obtaining assessment documentation from the member's licensed mental health professional. "Serious emotional disturbance" means the same as defined in rule 441—83.121(249A). "Serious mental illness" means, for an adult, a persistent or chronic mental health, behavioral, or emotional disorder that: (1) is specified within the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or its most recent International Classification of Diseases, and (2) causes serious functional impairment and substantially interferes with or limits one or more major life activities, including functioning in the family, school,	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: General Requirements		
Requirement: Member Eligibility	**Documentation**	**Met/Not Met**
employment, or community. "Serious mental illness" may co-occur with substance use disorder, developmental disabilities, neurodevelopmental disabilities, or intellectual disabilities, but those diagnoses may not be the clinical focus for health home services. "Functional impairment" means the loss of functional capacity that (1) is episodic, recurrent, or continuous; (2) substantially interferes with or limits the achievement of or maintenance of one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills; and (3) substantially interferes with or limits the individual's functional capacity with family, employment, school, or community. "Functional impairment" does not include difficulties resulting from temporary and expected responses to stressful events in a person's environment. The level of functional impairment must be identified by the assessment completed by a mental health professional, as defined in rule 441—24.1(225C) Eligible individuals agree to participate in the Health Home at the initial engagement of the provider in a Health Home Practice. A provider presents the qualifying member with the benefits of a Health Home and the member agrees to opt-in to health home services. The Health Home must explain to the member, in a format easily understood by the member, how the team works together with the member at the center to improve the member's care as well as all team member's roles and responsibilities. The Health Home must advise members of their ability and the process to opt-out of Health Home Services at any time. Eligible members must agree to participate in the Health Home Program and the Health Home must document the member's agreement in the member's record before submitting an enrollment request. A member cannot be in more than one Health Home at the same time. The Health Home must assess the member's continued eligibility for Health Home services on an annual basis to ensure the member remains eligible to participate in the program. 441—24 441—77.47 441—78.53 441—79.3		

Standard: General Requirements		
Requirement: Member Eligibility	**Documentation**	**Met/Not Met**
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Standard: General Requirements		
Requirement: Personal Provider for Each Member	**Documentation**	**Met/Not Met**
Ensure a personal provider for each member. Ensure each member has an ongoing relationship with a personal provider, physician, nurse practitioner, or physician assistant. 441—77.47 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met
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State Findings:		
State Identified Required Actions for Health Home:		

Standard: General Requirements		
Requirement: Health Home Services Comprehensive Care Management (CCM)	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) d. Core services. Documentation must reflect monthly provision of one of the six core health home services as outlined in subrule 78.53(2). b. Comprehensive assessment. The comprehensive assessment must include all aspects of a member's life and satisfy the following requirements: (1) The comprehensive assessment must be completed within 30 days of enrollment, and at least every 365 days, or more frequently when the member's needs or circumstances change significantly or at the request of the member or member's support. (2) The comprehensive assessment for members enrolled to receive non-intensive care management or enrolled in the chronic condition health home must include: 1. Assessment of the member's current and historical information provided by the member, the lead entity, and other health care providers that support the member; 2. Assessment of physical and behavioral health needs, medication reconciliation, functional limitations, and appropriate screenings; 3. Assessment of the member's social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors; and 4. Assessment of the member's readiness for self-management using screenings and assessments with standardized tools. (3) The comprehensive assessment for members enrolled to receive intensive care management must be in a format designated by the department and must include: 1. The member's relevant history, including the findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to complete the comprehensive assessment. 2. The member's physical, cognitive, and behavioral health care and support needs; strengths and preferences; available service and housing options; and, if unpaid caregivers will be relied upon to implement any elements of the person-centered service plan, a caregiver assessment. 3. Documentation that no state plan HCBS is provided that would otherwise be available to the member through other Medicaid services or other federally funded programs.	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: General Requirements		
Requirement: Health Home Services Comprehensive Care Management (CCM)	**Documentation**	**Met/Not Met**
4. For members receiving state plan HCBS and HCBS approved under 441—Chapter 83, documentation that HCBS provided through the state plan and waiver are not duplicative. c. Person-centered service plan and person-centered care plan. (1) For members receiving non-intensive care management or enrolled in the chronic condition health home, documentation must include a person-centered care plan that meets the requirements as defined in subrule 78.53(1) and the health home state plan amendment. (2) For members receiving intensive care management, documentation must include a service plan that meets the requirements of rule 441—78.27(249A) or 441—83.127(249A) and 441—paragraph 90.4(1)"b." (3) Documentation must reflect an update of the plan no less often than every 365 days and when significant changes occur in the member's support needs, situation, condition, or circumstances. The services included in this section are available to members enrolled in both fee-for-service and managed care. Health Home Services provide team-based, whole-person, patient-centered, coordinated care for all aspects of the member's life and for transitions of care that the individual may experience. **Comprehensive Care Management.** Comprehensive care management is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty healthcare, and community support services, using comprehensive person-centered care plan that addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes. • Outreach and engagement activities to members to gather information and engage in comprehensive care management. • Assessment of the member's current and historical information provided by the member, the Lead Entity, and other health care providers that supports the member. • Assessment includes a physical and behavioral assessment, medication reconciliation, functional limitations, and appropriate screenings, completed by a licensed health care professional within 30 days of enrolling. • Assess the member's social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors. • Assessing member's readiness for self-management using screenings and assessments with		

Standard: General Requirements		
Requirement: Health Home Services Comprehensive Care Management (CCM)	**Documentation**	**Met/Not Met**
standardized tools • Comprehensive Assessment is conducted at least every 12 months or more frequently as needed when the member's needs or circumstances change significantly or at the request of the member or member's support. • Creation of a person-centered care plans by a licensed health care professional with the member and individuals chosen by the member that address the needs of the whole person with input from the interdisciplinary team and other key providers . • Organize, authorize, and administer joint treatment planning with local providers, members, families, and other social supports to address total health needs of members. • Wraparound planning process: identification, development and implementation of strengths-based individualized person-centered care plans addressing the needs of the whole child and family. • At least monthly reporting of member gaps in care and predicted risks based on medical and behavioral claims data matched to Standard of Care Guidelines • Information technology functionality developed to allow online receipt of standardized Continuity of Care Document (CCD). • Continuous claims-based monitoring of care to ensure evidence-based guidelines are being addressed with members /families. • Serve as communication hub facilitating the timely sharing of information across providers 24 hours/day, 7 days/week. • Serve as active team member, monitoring and intervening on progress of member treatment goals using holistic clinical expertise. • Assignment of team roles and responsibilities 441 — 78.27 441—78.53 441—79.3 441—83.127 441—90.4 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		

Standard: General Requirements		
Requirement: Health Home Services Comprehensive Care Management (CCM)	**Documentation**	**Met/Not Met**
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: General Requirements		
Requirement: Health Home Services Care Coordination	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) d. Core services. Documentation must reflect monthly provision of one of the six core health home services as outlined in subrule 78.53(2). The services included in this section are available to members enrolled in both fee-for-service and managed care. Health Home Services provide team-based, whole-person, patient-centered, coordinated care for all aspects of the member's life and for transitions of care that the individual may experience. **Care Coordination.** Care coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, and transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. Coordinate, direct, and ensure results are communicated back to the Health Home. • Implementation of a Person-Centered Care Plan • Outreach activities to members to engage in care coordination • Continuous monitoring of progress towards goals identified in the person-centered care plan though face-to-face and collateral contacts with member, member's supports, primary care, and specialty care	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: General Requirements		
Requirement: Health Home Services Care Coordination	**Documentation**	**Met/Not Met**
• Scheduling appointments • Making referrals • Tracking referrals and appointments • Follow-up monitoring • Communicating with providers on interventions/goals • Conducting joint treatment staffing: meeting with multidisciplinary treatment team and member/parent/guardian to plan for treatment and coordination • Support coordination of care with primary care providers and specialists • Addressing barriers to treatment plan • Coordinate multiple systems for children with SED as part of a child and family-driven team process • Appropriately arrange care with other qualified professionals for all the member's health care needs. This includes care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care 441—78.53 441—79.3 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: General Requirements		
Requirement: Health Home Services Health Promotion	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to	**Required Evidence:**	☐ Met

Standard: General Requirements		
Requirement: Health Home Services Health Promotion	**Documentation**	**Met/Not Met**
ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) d. Core services. Documentation must reflect monthly provision of one of the six core health home services as outlined in subrule 78.53(2). The services included in this section are available to members enrolled in both fee-for-service and managed care. Health Home Services provide team-based, whole-person, patient-centered, coordinated care for all aspects of the member's life and for transitions of care that the individual may experience. **Health Promotion.** Health promotion means the education and engagement of a member in making decisions that promotes health management, improved disease outcomes, disease prevention, safety, and an overall healthy lifestyle. • Promoting members' health and ensuring that all personal health goals are included in person-centered care management plans. • Promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction, and increased physical activity. • Providing health education to members and family members about preventing and managing chronic conditions using evidence-based sources. • Provide prevention education to members and family members about health screening, childhood developmental assessments and immunization standards. • Providing self-management support and development of self-management plans and/or relapse prevention plans so that members can attain personal health goals. • Using motivational interviewing, trauma-informed care, and other evidenced based practices to engage and help the member in participating and managing their own care. • Promoting self-direction and skill development in the area of independent administering of medication and medication adherence. • Provide prevention education to members and family members about health screening, childhood developmental assessments and immunization standards. • Increasing health literacy and self-management skills (i.e., WRAP). • Education or training in self-management of chronic diseases.	• Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Not Met

Standard: General Requirements		
Requirement: Health Home Services Health Promotion	**Documentation**	**Met/Not Met**
441—78.53 441—79.3 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: General Requirements		
Requirement: Health Home Services Comprehensive Transitional Care	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) d. Core services. Documentation must reflect monthly provision of one of the six core health home services as outlined in subrule 78.53(2). The services included in this section are available to members enrolled in both fee-for-service and managed care. Health Home Services provide team-based, whole-person, patient-centered, coordinated care for all aspects of the member's life and for transitions of care that the individual may experience. **Comprehensive Transitional Care**. Comprehensive transitional care is the facilitation of services for the member that providers support for when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community-based group home, family, self-care, or another Health Home). • Engage member and/or caregiver as an alternative to emergency room or hospital care	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: General Requirements		
Requirement: Health Home Services Comprehensive Transitional Care	**Documentation**	**Met/Not Met**

• Facilitate development of crisis plans.
• Monitor for potential crisis escalation/need for intervention.
• Follow-up phone calls and face-to-face visits with members/families after discharge from the emergency room or hospital
• Identification and linkage to long-term care and home and community-based services
• Develop relationships with hospitals and other institutions and community providers to ensure efficient and effective care transitions.
• Provide prompt notification of member's admission/ discharge to and from an emergency department, inpatient residential, rehabilitative, or other treatment settings to the member's medical care physician and community support providers with the intent of coordinating care.
• Active participation in discharge planning to ensure consistency in meeting the goals of the member's person-centered plan.
• Communicating with and providing education to the provider where the member is currently being served and the location where the member is transitioning.
• Ensure the following:
  ○ Receipt of a CCD from the discharging entity
  ○ Medication reconciliation
  ○ Reevaluation of the care plan to include and provide access to needed community supports that includes short-term and long-term care coordination needs resulting from the transition.
  ○ Plan to ensure timely scheduled appointments.
• Facilitate transfer from a pediatric to an adult system of health care.
• The Teams of Health Care Professionals shall establish personal contact with the member regarding all needed follow-up after the transition.
441—78.53
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Health Home's Description of Process:		
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Standard: General Requirements		
Requirement: Health Home Services Comprehensive Transitional Care	**Documentation**	**Met/Not Met**
State Findings:		
State Identified Required Actions for Health Home:		

Standard: General Requirements		
Requirement: Health Home Services Individual and Family Support	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) d. Core services. Documentation must reflect monthly provision of one of the six core health home services as outlined in subrule 78.53(2). The services included in this section are available to members enrolled in both fee-for-service and managed care. Health Home Services provide team-based, whole-person, patient-centered, coordinated care for all aspects of the member's life and for transitions of care that the individual may experience. **Individual and Family Support.** Individual and Family Support Services include communication with member, family, and caregivers to maintain and promote the quality of life with particular focus on community living options. Support will be provided in culturally appropriate manner. • Providing assistance to members in accessing needed self-help and peer/family support services • Advocacy for members and families • Education regarding concerns applicable to the member • Education or training in self-management of chronic diseases • Family support services for members and their families • Assisting members to identify and develop social support networks. • Assistance with medication and treatment management and adherence • Identifying community resources that will help members and their families reduce barriers to their highest level of health and success.	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:**	☐ Met ☐ Not Met

Standard: General Requirements		
Requirement: Health Home Services Individual and Family Support	**Documentation**	**Met/Not Met**
• Linkage and support for community resources, insurance assistance, waiver services • Connection to peer advocacy groups, family support networks, wellness centers, NAMI, and family Psychoeducational programs • Assisting members in meeting their goals 441—78.53 441—79.3 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: General Requirements		
Requirement: Health Home Services Referral to Community and Social Support Services	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) d. Core services. Documentation must reflect monthly provision of one of the six core health home services as outlined in subrule 78.53(2). The services included in this section are available to members enrolled in both fee-for-service and managed care. Health Home Services provide team-based, whole-person, patient-centered, coordinated care for all aspects of the member's life and for transitions of care that the individual may experience. **Referral to Community and Social Support Services.** Referral to community and social	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: General Requirements		
Requirement: Health Home Services Referral to Community and Social Support Services	**Documentation**	**Met/Not Met**
support services includes coordinating or providing recovery services and social health services available in the community, such as understanding eligibility for various healthcare programs, disability benefits, and identifying housing programs. • Resources to reduce barriers to assist members in achieving their highest level of function with independence. • Primary care providers and specialists • Wellness programs, including tobacco cessation, fitness, nutrition or weight management programs, and exercise facilities or classes. • Specialized support groups (i.e., cancer or diabetes support groups, NAMI psychoeducation) • School supports. • Substance treatment links in addition to treatment -- supporting recovery with links to support groups, recovery coaches, and 12-step programs. • Iowa Department of Public Health (IDPH) Programs • Housing services Housing and Urban Development (HUD), rental assistance program through the Iowa Finance authority • Food Assistance Iowa Department of Human Services (DHS), Food Bank of Iowa • Transportation services (NEMT), free or low-cost public transportation • Programs that assist members in their social integration and social skill building • Faith-based organizations • Employment and educational programs or training, Iowa Workforce Development (IWD), Iowa Vocational Rehab Services (IVRS) • Volunteer opportunities • Monitor and follow-up with referral source, member, and member's support to ensure that members are engaged with the service. 441—78.53 441—79.3 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
Health Home's Description of Process:		
Health Home's Remediation Plan:		

Standard: General Requirements		
Requirement: Health Home Services Referral to Community and Social Support Services	**Documentation**	**Met/Not Met**
State Findings:		
State Identified Required Actions for Health Home:		

Standard: General Requirements		
Requirement: Duplication of Services	**Documentation**	**Met/Not Met**
A member cannot be in more than one Health Home at the same time. Members in the IHH will have state plan services coordinated through the Integrated Health Home Provider. If a member receives case management through a waiver to the State Plan and also qualifies for the Integrated Health Home, the Health Home must collaborate with the Community-Based Case Manager (CBCM), and Service Coordinators to ensure the care plan is complete and not duplicative between the two entities at a minimum of at least quarterly. Costs for Health Home services are not reimbursable while the member resides in a Mental Health Institution or Long-Term Care Facility (SNF, NF, or ICF for members with intellectual disabilities) To avoid duplication of services, members who are enrolled in the 1915i Habilitation program and concurrently enrolled in a 1915c waiver program, will receive their coordination of services through the Community-Based Case Manager. Members may choose to be enrolled with the Integrated Health Home at a tier 5 or 6. The CBCM and Integrated Health Home will work together to ensure non-duplication of services. A member cannot be in more than one Health Home at the same time. Members in the IHH will have state plan services coordinated through the Integrated Health Home Provider. If a member receives case management through a waiver to the State Plan and also qualifies for the Integrated Health Home, the Health Home must collaborate with the Community-Based Case Manager (CBCM), and Service Coordinators to ensure the care plan is complete and not duplicative between the two entities at a minimum of at least quarterly.	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: General Requirements		
Requirement: Duplication of Services	**Documentation**	**Met/Not Met**
Integrated Health Home State Plan Amendment		
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: General Requirements		
Requirement: Disenrollment	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) g. Disenrollment. Members are able to opt out of health home services at any time. The health home must document a member's request to disenroll from health home services, the reason for disenrollment, how the member's needs will be supported after disenrollment, and that the health home has advised the member of the ability to re-enroll if circumstances change. 441—78.53 441—79.3 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: ICM Requirements		
Requirement: General Case Management	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) e. Intensive health home services. A health home must provide documentation to justify provision of more intensive health home services, including documentation that the member is enrolled to receive services through the HCBS habilitation or HCBS children's mental health waiver programs. e. Case management. The integrated health home must provide case management services as defined in and required by 441—Chapter 90 to eligible members in an integrated health home. Requirements in 441—Chapter 90 are the minimum criteria for intensive care management for members enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver. Minimum Criteria for Intensive Care Management (ICM) members that are enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver. Case managers shall make contacts with the member, the member's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements: in accordance with 441 Iowa Administrative Code Chapter 90. 441—77.47 441—78.53 441 — 79.3 441—90.4 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: ICM Requirements		
Requirement: Comprehensive Assessment	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) e. Intensive health home services. A health home must provide documentation to justify provision of more intensive health home services, including documentation that the member is enrolled to receive services through the HCBS habilitation or HCBS children's mental health waiver programs. e. Case management. The integrated health home must provide case management services as defined in and required by 441—Chapter 90 to eligible members in an integrated health home. Requirements in 441—Chapter 90 are the minimum criteria for intensive care management for members enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver Case managers shall make contacts with the member, the member's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements: in accordance with 441 Iowa Administrative Code Chapter 90. e. Needs assessment. The LOCUS or CALOCUS tool has been completed in the LOCUS online system, and using the algorithm developed by Deerfield Solutions to derive the actual disposition score based on the comprehensive assessment and social history (CASH) completed by the integrated health home (IHH) or community-based case manager (CBCM) during a face-to-face interview with the member and the member's representative as applicable. a. Assessment. Initial assessments and regular reassessments must be done for each applicant and member to determine the need for any medical, social, educational, housing, transportation, vocational, or other services. The assessments and reassessments shall address all of the applicant's and member's areas of need, strengths, preferences, and risk factors, considering the person's physical and social environment. Applicants and members will receive individualized prior notification of the assessment tool to be used and of who will conduct the assessment. The assessment and reassessment will be done using the core standardized assessment or another tool as designated in 441—Chapter 83 for each waiver population and 441—Chapter 78 for the habilitation population. Initial assessments must be face to face. Reassessments using the interRAI must be done face to face. A reassessment must be conducted at a minimum every 365 days and more frequently if material changes occur in the member's condition or circumstances. Case managers may participate during the assessment or reassessment process at the request of the applicant or member; the case manager does not assume the role of the assessor. Assessment Requirements. The Contractor shall administer all HCBS level of care and needs-based	**Required Evidence:** • Policies and processes • Include policies and processes for ensuring access to IoWANS to submit the CASH. **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: ICM Requirements		
Requirement: Comprehensive Assessment	**Documentation**	**Met/Not Met**
eligibility assessments in accordance with the following requirements: a) Enrolled Members shall have the ability to have others present of their choosing; b) Enrolled Members and chosen team members shall receive notice to schedule no less than fourteen (14) Days prior to current assessment end date; c) Enrolled Members and chosen team members shall receive a copy of the completed assessment within three (3) business days of the assessment; d) Enrolled Members and chosen team members shall receive information related to the assessment results in a manner that is meaningful to the team; 441—77.47 441—78.27 441—78.53 441—79.3 441—83.121 411 — 83.122 441—90.4 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment MED – 24-006 Contract F12B.10		
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: ICM Requirements		
Requirement: Person-Centered Planning	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health	**Required Evidence:** • Policies and processes	☐ Met ☐ Not Met

Standard: ICM Requirements		
Requirement: Person-Centered Planning	**Documentation**	**Met/Not Met**
home services must be documented in accordance with rule 441—79.3(249A) e. Intensive health home services. A health home must provide documentation to justify provision of more intensive health home services, including documentation that the member is enrolled to receive services through the HCBS habilitation or HCBS children's mental health waiver programs. e. Case management. The integrated health home must provide case management services as defined in and required by 441—Chapter 90 to eligible members in an integrated health home. Requirements in 441—Chapter 90 are the minimum criteria for intensive care management for members enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver Minimum Criteria for Intensive Care Management (ICM) members that are enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver. Case managers shall make contacts with the member, the member's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements: in accordance with 441 Iowa Administrative Code Chapter 90. f. Plan for service. The department or the member's managed care organization has approved the member's comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated by the IME or the member's managed care organization shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member's eligibility for the program cannot be reimbursed. (1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4) and 441—paragraph 90.4(1)"b." A service plan may change when requested by the member or the member's interdisciplinary team when there is a significant observable change in the member's situation, condition, or circumstances. (2) For members receiving home-based habilitation, the service plan shall include the member's LOCUS/CALOCUS actual disposition, the LOCUS/CALOCUS composite score, and each individual domain score for each of the six LOCUS/CALOCUS domains. (3) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2). (4) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2). (2) Person-centered planning shall be implemented in a manner that supports the member, makes	**Evidence as Submitted by the Health Home:** •	

Standard: ICM Requirements		
Requirement: Person-Centered Planning	**Documentation**	**Met/Not Met**
the member central to the process, and recognizes the member as the expert on goals and needs. In order for this to occur, there are certain process elements that must be included in the process. These include: 1. The member, guardian or representative must have control over who is included in the planning process, as well as have the authority to request meetings and revise the person-centered service plan (and any related budget) whenever reasonably necessary. 2. The process is timely and occurs at times and locations of convenience to the member, the member's guardian or representative and family members, and others, as practicable. 3. Necessary information and support are provided to ensure that the member or the member's guardian or representative is central to the process and understands the information. This includes the provision of auxiliary aids and services when needed for effective communication. 4. A strengths-based approach to identifying the positive attributes of the member shall be used, including an assessment of the member's strengths and needs. The member should be able to choose the specific planning format or tool used for the planning process. 5. The member's personal preferences shall be considered to develop goals and to meet the member's HCBS needs. 6. The member's cultural preferences must be acknowledged in the planning process, and policies/practices should be consistent with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) of the Office of Minority Health, U.S. Department of Health and Human Services. 7. The planning process must provide meaningful access to members and their guardians or representatives with limited English proficiency (LEP), including low literacy materials and interpreters. 8. Members who are under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, must have the opportunity in the planning process to address any concerns. 9. There shall be mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines. 10. Members shall be offered information on the full range of HCBS available to support achievement of personally identified goals. 11. The member or the member's guardian or representative shall be central in determining what available HCBS are appropriate and will be used.		

Standard: ICM Requirements		
Requirement: Person-Centered Planning	**Documentation**	**Met/Not Met**
12. The member shall be able to choose between providers or provider entities, including the option of self-directed services when available. 13. The person-centered service plan shall be reviewed at least every 365 days or sooner if the member's functional needs change, circumstances change, or quality of life goals change, or at the member's request. There shall be a clear process for members to request reviews. The case management entity must respond to such requests in a timely manner that does not jeopardize the member's health or safety. 14. The planning process should not be constrained by any case manager's or guardian's or representative's preconceived limits on the member's ability to make choices. 15. Employment and housing in integrated settings shall be explored, and planning should be consistent with the member's goals and preferences, including where the member resides and with whom the member lives. 441—77.47 441—78.27 441—78.53 441—79.1 441—79.3 441—90.4 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: ICM Requirements		
Requirement: Person-Centered Service Plan	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) e. Intensive health home services. A health home must provide documentation to justify provision of more intensive health home services, including documentation that the member is enrolled to receive services through the HCBS habilitation or HCBS children's mental health waiver programs. e. Case management. The integrated health home must provide case management services as defined in and required by 441—Chapter 90 to eligible members in an integrated health home. Requirements in 441—Chapter 90 are the minimum criteria for intensive care management for members enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver Minimum Criteria for Intensive Care Management (ICM) members that are enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver. Case managers shall make contacts with the member, the member's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements: in accordance with 441 Iowa Administrative Code Chapter 90. Comprehensive service plan. Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes. a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis. (1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team as selected by the member or the member's legal representative. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved with the member. (2) With assistance from the member and the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers. (3) The comprehensive service plan development shall be completed at the member's home or at	**Required Evidence:** • Policies and processes • Include policies and processes for ensuring access to IoWANS to submit the plan. **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: ICM Requirements		
Requirement: Person-Centered Service Plan	**Documentation**	**Met/Not Met**
another location chosen by the member. (4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires. (5) The comprehensive service plan shall reflect desired individual outcomes. (6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities. (7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process. (8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration. (9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the IME medical services unit in ISIS (IoWANS) before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager or integrated health home care coordinator within 30 calendar days after plan approval. (10) Any changes to the comprehensive service plan or treatment plan must be approved by the IME medical services unit for members not eligible to enroll in a managed care organization in ISIS (IoWANS) before the implementation of services. Services provided before the approval date are not payable. b. Service goals and activities. The comprehensive service plan shall: (1) Identify observable or measurable individual goals. (2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate. (3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports. (4) List all Medicaid and non-Medicaid services received by the member and identify: 1. The name of the provider responsible for delivering the service; 2. The funding source for the service; and 3. The number of units of service to be received by the member.		

Standard: ICM Requirements		
Requirement: Person-Centered Service Plan	**Documentation**	**Met/Not Met**
(5) Identify for a member receiving home-based habilitation: 1. The member's living environment at the time of enrollment; 2. The number of hours per day of on-site staff supervision needed by the member; and 3. The number of other members who will live with the member in the living unit. (6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives. b. Person-centered service plan. At least every 365 days, the case manager shall develop and revise a comprehensive, person-centered service plan in collaboration with the member, the member's service providers, and other people identified as necessary by the member, as practicable. The person-centered service plan will be developed based on the assessment and shall include a crisis intervention plan based on the risk factors identified in a risk assessment. The case manager shall document the member's history, including current and past information and social history, and shall update the history annually. The case manager shall gather information from other sources such as family members, medical providers, social workers, guardians, representatives, and others as necessary to form a thorough social history and comprehensive person-centered service plan with the member. The person-centered service plan may also be referred to as a person-centered treatment plan. (1) The person-centered service plan shall address all service plan components outlined in this chapter and in 441—Chapter 83 for the waiver in which the member is enrolled or 441—Chapter 78 for members enrolled in habilitation. (3) Elements of the person-centered service plan. The person-centered service plan shall identify the services and supports that are necessary to meet the member's identified needs, preferences, and quality of life goals. The person-centered service plan shall: 1. Reflect that the setting where the member resides is chosen by the member. The chosen setting must be integrated in, and support 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 to the same degree of access as individuals not receiving HCBS. 2. Be prepared in person-first singular language and be understandable by the member or the member's guardian or representative. 3. Note the strengths-based positive attributes of the member at the beginning of the plan.		

Standard: ICM Requirements		
Requirement: Person-Centered Service Plan	**Documentation**	**Met/Not Met**
4. Identify risks, while considering the member's right to assume some degree of personal risk and include measures available to reduce risks or identify alternate ways to achieve personal goals. 5. Document goals in the words of the member or the member's guardian or representative, with clarity regarding the amount, duration, and scope of HCBS services that will be provided to assist the member. Goals shall consider the quality-of-life concepts important to the member. 6. Describe the services and supports that will be necessary and specify what HCBS services are to be provided through various resources, including natural supports, to meet the goals in the person-centered service plan. 7. Document the specific person or persons, provider agency and other entities providing services and supports. 8. Ensure the health and safety of the member by addressing the member's assessed needs and identified risks. 9. Document non-paid supports and items needed to achieve the goals. 10. Include the signatures of everyone with responsibility for the plan's implementation, including the member or the member's guardians or representatives, the case manager, the support broker/agent (when applicable), and providers, and include a timeline for review of the plan. The plan must be discussed with family, friends, and caregivers designated by the member so that they fully understand it and their roles. 11. Identify each person and entity responsible for monitoring the plan's implementation. 12. Identify needed services based upon the assessed needs of the member and prevent unnecessary or inappropriate services and supports not identified in the assessed needs of the member. 13. Document an emergency back-up plan that encompasses a range of circumstances (e.g., weather, housing, and staff). 14. Address elements of self-direction through the consumer choices option (e.g., financial management service, support broker/agent, alternative services) whenever the consumer choices option is chosen. 15. Be distributed directly to all parties involved in the planning process. e. Plan approval. Services shall be entered into ISIS (IoWANS) based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS (IoWANS) shall be considered approved by the department. Services must be authorized in ISIS (IoWANS) as specified in paragraph 78.27(2)"f."		

Standard: ICM Requirements		
Requirement: Person-Centered Service Plan	**Documentation**	**Met/Not Met**
441—77.47 441—78.27 441—78.53 441—79.3 411— 83.122 441—83.127 441—90.4 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: ICM Requirements		
Requirement: Person-Centered Service Plan - Emergency Plan	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) e. Intensive health home services. A health home must provide documentation to justify provision of more intensive health home services, including documentation that the member is enrolled to receive services through the HCBS habilitation or HCBS children's mental health waiver programs. e. Case management. The integrated health home must provide case management services as defined in and required by 441—Chapter 90 to eligible members in an integrated health home. Requirements in 441—Chapter 90 are the minimum criteria for intensive care management for members enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: ICM Requirements		
Requirement: Person-Centered Service Plan - Emergency Plan	**Documentation**	**Met/Not Met**
Waiver d. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows: (1) The member's interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment. (2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. (3) Providers of applicable services shall provide for emergency backup staff 441—78.27 441—78.53 441—79.3 441—90.4 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: ICM Requirements		
Requirement: Person Centered Service Plan - Rights Restrictions	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to	**Required Evidence:**	☐ Met

Standard: ICM Requirements		
Requirement: Person Centered Service Plan - Rights Restrictions	**Documentation**	**Met/Not Met**
ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) e. Intensive health home services. A health home must provide documentation to justify provision of more intensive health home services, including documentation that the member is enrolled to receive services through the HCBS habilitation or HCBS children's mental health waiver programs. e. Case management. The integrated health home must provide case management services as defined in and required by 441—Chapter 90 to eligible members in an integrated health home. Requirements in 441—Chapter 90 are the minimum criteria for intensive care management for members enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of: (1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications; (2) The need for the restriction; and (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate. 441—77.25(4) 441—78.27 441—78.53 441—79.3 441—90.4 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment	• Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Not Met
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: ICM Requirements		
Requirement: Case Management Activities	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) e. Intensive health home services. A health home must provide documentation to justify provision of more intensive health home services, including documentation that the member is enrolled to receive services through the HCBS habilitation or HCBS children's mental health waiver programs. e. Case management. The integrated health home must provide case management services as defined in and required by 441—Chapter 90 to eligible members in an integrated health home. Requirements in 441—Chapter 90 are the minimum criteria for intensive care management for members enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver Minimum Criteria for Intensive Care Management (ICM) members that are enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver. Case managers shall make contacts with the member, the member's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements: in accordance with 441 Iowa Administrative Code Chapter 90. c. Referral and related activities. The case manager shall assist, as needed, the member in obtaining needed services, such as by scheduling appointments for the member and by connecting the member with medical, social, educational, housing, transportation, vocational or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the person-centered service plan. d. Monitoring and follow-up. The case manager shall perform monitoring activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the person-centered service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home, when applicable), and all services regardless of the service funding stream. Monitoring shall also include review of service provider documentation. Monitoring of the following aspects of the person-centered service plan shall lead to revisions of the plan if deficiencies are noted: (1) Services are being furnished in accordance with the member's person-centered service plan, including the amount of service provided and the member's attendance and participation in the service;	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: ICM Requirements		
Requirement: Case Management Activities	**Documentation**	**Met/Not Met**
(2) The member has declined services in the service plan; (3) Communication among providers is occurring, as practicable, to ensure coordination of services; (4) Services in the person-centered service plan are adequate, including the member's progress toward achieving the goals and actions determined in the person-centered service plan; and (5) There are changes in the needs or circumstances of the member. Follow-up activities shall include making necessary adjustments in the person-centered service plan and service arrangements with providers. e. Contacts. Case managers shall make contacts with the member, the member's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements: (1) The case manager shall have at least one face-to-face contact with the member in the member's residence at least quarterly; (2) The case manager shall have at least one contact per month with the member or the member's guardians or representatives. This contact may be face to face or by telephone; 441—77.47 441—78.27 441—78.53 441—79.3 441—90.4 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: ICM Requirements		
Requirement: PMPM Payment Exclusions	**Documentation**	**Met/Not Met**
90.4(2) Exclusions. Payment shall not be made for activities otherwise within the definition of case management services when any of the following conditions exist: a. The activities are an integral component of another covered Medicaid service. b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred. Such services include but are not limited to: (1) Services under parole and probation programs; (2) Public guardianship programs; (3) Special education programs; Ch 90, p.4 IAC (4) Child welfare and child protective services; or (5) Foster care programs. c. The activities are components of the administration of foster care programs, including but not limited to the following: (1) Research gathering and completion of documentation required by the foster care program; (2) Assessing adoption placements; (3) Recruiting or interviewing potential foster care parents; (4) Serving legal papers; (5) Conducting home investigations; (6) Providing transportation related to the administration of foster care; (7) Administering foster care subsidies; or (8) Making placement arrangements. d. The activities for which a member may be eligible are a component of the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act. e. The activities duplicate institutional discharge planning. 441—90.4 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: ICM Requirements		
Requirement: PMPM Payment Exclusions	**Documentation**	**Met/Not Met**
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: ICM Requirements		
Requirement: Children's Mental Health Waiver	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) e. Intensive health home services. A health home must provide documentation to justify provision of more intensive health home services, including documentation that the member is enrolled to receive services through the HCBS habilitation or HCBS children's mental health waiver programs. e. Case management. The integrated health home must provide case management services as defined in and required by 441—Chapter 90 to eligible members in an integrated health home. Requirements in 441—Chapter 90 are the minimum criteria for intensive care management for members enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver Eligibility. To be eligible for children's mental health waiver services, a consumer must meet all of the following requirements: 83.122(1) Age. The consumer must be under 18 years of age. 83.122(2) Diagnosis. The consumer must be diagnosed with a serious emotional disturbance. a. Initial certification. For initial application to the HCBS children's mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date. b. Ongoing certification. A mental health professional must complete an annual evaluation that	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met ☐ NA

Standard: ICM Requirements		
Requirement: Children's Mental Health Waiver	**Documentation**	**Met/Not Met**
substantiates a mental health diagnosis of serious emotional disturbance 441—77.47 441—78.53 411—83.122 441—90.4 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Standard: ICM Requirements		
Requirement: Habilitation Only	**Documentation**	**Met/Not Met**
A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A) e. Intensive health home services. A health home must provide documentation to justify provision of more intensive health home services, including documentation that the member is enrolled to receive services through the HCBS habilitation or HCBS children's mental health waiver programs. e. Case management. The integrated health home must provide case management services as defined in and required by 441—Chapter 90 to eligible members in an integrated health home. Requirements in 441—Chapter 90 are the minimum criteria for intensive care management for members enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver	**Required Evidence:** • Policies and processes **Evidence as Submitted by the Health Home:** •	☐ Met ☐ Not Met

Standard: ICM Requirements		
Requirement: Habilitation Only	**Documentation**	**Met/Not Met**
78.27(3) Application for services. The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the IME medical services unit. The department shall issue a notice of decision to the applicant when financial eligibility and needs-based eligibility determinations have been completed. 441—77.47 441—78.27 441—78.53 441—90.4 Integrated Health Home Provider Manual Integrated Health Home State Plan Amendment		
Health Home's Description of Process:		
Health Home's Remediation Plan:		
State Findings:		
State Identified Required Actions for Health Home:		

Additional Resources to reference include:

- Integrated Health Home State Plan Amendment
- Integrated Health Home Provider Manual
- Reporting Guide Matrix
- Amerigroup Iowa IHH Supplement Manual
- Amerigroup LTSS Pre-Delegation Agreement
- Iowa Total Care LTSS Delegation Agreement
- MCO Contract
- Chart Review Workbook
- Community-Based Case Manager (CBCM) & Integrated Health Home (IHH) Roles and Responsibilities Document
- MCO Documentation Expectations

Guarantee of Accuracy

In submitting this Annual Health Home Provider Quality Self-Assessment and signing this Guarantee of Accuracy, the organization and all signatories jointly and severally certify that the information and responses on contained within are true, accurate, complete, and verifiable. Further, the organization and all signatories each acknowledge
(1) familiarity with the laws and regulations governing the Iowa Medicaid program;
(2) the responsibility to request technical assistance from the Managed Care Organizations in order to achieve compliance with the standards listed within this assessment;
(3) the Department, or an authorized representative, may conduct desk or on-site reviews on a periodic basis, as initiated by random sampling or as a result of a complaint.

NOTICE: Any person that submits a false statement, response, or representation, or any false, incomplete, or misleading information, may be subject to criminal, civil, or administrative liability.

Identify any accreditation, licensure or certification held, including those which qualify your organization to provide HCBS including the start and end dates of each. Dates should be listed in MM/YYYY format.

Community mental health center accredited under 441—Chapter 24. ☐		Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide behavioral health services. ☐	
Start Date	End Date	Start Date	End Date
Licensed mental health service provider. ☐		Accredited by the Council on Accreditation (COA) for behavioral health or child, youth and family services. ☐	
Start Date	End Date	Start Date	End Date
Licensed residential group care setting. ☐		Accredited by the Joint Commission for behavioral health care services. ☐	
Start Date	End Date	Start Date	End Date
Licensed psychiatric medical institution for children (PMIC). ☐		Accredited under 441—Chapter 24 to deliver services to persons with mental illness. ☐	

Start Date	End Date		Start Date	End Date

Is your organization in good standing with the identified accreditation, licensing, or certifying entity? ☐ Yes ☐ No *If your organization received less than the maximum level of accreditation or certification with the identified accreditation, licensing, or certifying entity, you must also provide the review results and any remediation plans when submitting this Provider Quality Self-Assessment.
Is your organization in good standing with the Iowa Secretary of State's Office? ☐ Yes ☐ No
Printed Name of Organization
Printed Signature* of the Executive Director
Printed Signature* of the Health Home Director
Printed Signature* of Chairperson, Board of Directors

***By typing my name, I am electronically signing this document in accordance with Iowa Code Chapter 554D.**