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State/Territory Name: Iowa

State Plan Amendment (SPA) #: 23-0023

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

June 13, 2024

Elizabeth Matney
Medicaid Director
Department of Human Services
Iowa Medicaid Enterprise
1305 East Walnut Street
Des Moines, IA 50319

RE: TN 23-0023 §1915(i) home and community-based services (HCBS) Habilitation state plan amendment (SPA)

Dear Director Matney:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its 1915(i) state plan home and community-based services (HCBS) benefit, transmittal number TN 23-0023. The effective date for this amendment is November 1, 2023. With this amendment, the state will permanently adopt COVID-19 PHE flexibilities; and add Remote Supports & Host Home Service modalities to align with the state's 1915(c) HCBS waivers.

Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:
• Attachment 3.1-C pages 13-20; 27-27j; 44-45a; 50-50; and 55-86
• Attachment 4.19-B pages 18 and 18a

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the ARP. Approval of this action does not constitute approval of the state's spending plan.

It is important to note that CMS' approval of this change to the state's 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (206) 615-3814. You may also contact Kijhana Glasco at 303-844-7131 or Kijhana.Glasco@cms.hhs.gov

Sincerely,

Wendy E. Hill Petras -S

Digitally signed by Wendy E. Hill Petras -S
Date: 2024.06.13 12:05:37 -07'00'

Wendy Hill Petras, Deputy Director
Division of HCBS Operations and Oversight

Enclosure

cc:
Jennifer Steenblock, Iowa
Jeanette Brandner, Iowa
LeeAnn Moskowitz, Iowa
Kim Grasty, Iowa
Paula Motsinger, Iowa
Lee Herko, CMS
Bernice Denbow, CMS
Essence Mc Knight, CMS
Lindsey Michael, CMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0023

2. STATE: IA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
November 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. §447.200

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 24 $ 322,076
b. FFY 25 $ 322,076

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B pages 18 and 18a
Attachment 3.1-C pages 13-20; 27-27j 44-45a; 50-50a; 55-86

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supersedes TN No.
IA-22-0016 (4.19-B pages 18 and 18a)
IA-21-0010 (3.1-C pages 13 and 14; 27-27e; 44-45a; 50-50a; 55-86)

9. SUBJECT OF AMENDMENT

State Plan HCBS HAB:1. Permanently adopt COVID-19 PHE flexibilities 2. add Remote Supports & Host Home Service Delivery M

10. GOVERNOR'S REVIEW *(Check One)*

(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
Elizabeth Matney

12. TYPED NAME
Elizabeth Matney

13. TITLE
Medicaid Director

14. DATE SUBMITTED
09/12/2023

15. RETURN TO
Elizabeth Matney
Medicaid Director
Department of Human Services
Iowa Medicaid Enterprise
1305 East Walnut Street
Des Moines, IA 50319

FOR CMS USE ONLY

16. DATE RECEIVED
9/12/2023

17. DATE APPROVED
June 13, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
November 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
Wendy E. Hill Petras -S
Digitally signed by Wendy E. Hill Petras -S
Date: 2024.06.13 12:06:07 -07'00'

20. TYPED NAME OF APPROVING OFFICIAL
Wendy Hill Petras

21. TITLE OF APPROVING OFFICIAL
Deputy Director Division of HCBS Operations and Oversight

22. REMARKS

Approved pen and ink change box 7
Included amendment will add Remote Supports & Host Home Service Delivery Models under Home-Based Habilitation 3. add Enabling Technology for Remote Support. box 9

Instructions on Back

INSTRUCTIONS FOR COMPLETING FORM CMS-179

Use Form CMS-179 to transmit State plan material to the Center for Medicaid & CHIP Services for approval. Submit a separate typed transmittal form with each plan/amendment.

Block 1 - Transmittal Number - Enter the State Plan Amendment transmittal number. Assign consecutive numbers on a **calendar year** basis with the first two digits being the two-digit year (e.g., 21-0001, 21-0002, etc.). Because states have different state fiscal years, a calendar year is required for consistency.

Block 2 - State - Enter the two-letter abbreviation code of the State/District/Territory submitting the plan material.

Block 3 - Program Identification - Enter the applicable Title of the Social Security Act (Title XIX Medicaid or Title XXI CHIP).

Block 4 - Proposed Effective Date - Enter the proposed effective date of material. The effective date of a new plan may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted. With respect to expenditures for assistance under such plan, the effective date may not be earlier than the first day on which the plan is in operation on a statewide basis or earlier than the day following publication of notice of changes.

Block 5 - Federal Statute/Regulation Citation - Enter the appropriate statutory/regulatory citation.

Block 6 - Federal Budget Impact - 6(a) - IN WHOLE DOLLARS, NOT IN THOUSANDS, Enter 1st **Federal Fiscal Year** (FFY) impacted by the SPA & estimated Federal share of the cost of the SPA for 1st FFY. The first FFY should be the FFY inclusive of the earliest effective date of any amended payment language; **6 (b)** - Enter 2nd FFY impacted by the SPA & estimated Federal share of the cost for 2nd FFY. In general, the estimates should include any amount not currently approved in the state's plan for assistance.

Block 7 - Page No.(s) of Plan Section or Attachment - Enter the page number(s) of plan material amended and transmitted. If additional space is needed, use bond paper. **New pages** should be included in Block 7, but not in Block 8.

Block 8 - Page No.(s) of the Superseded Plan Section or Attachment (if Applicable) - Enter the page number(s) (including the transmittal number) that is being superseded. If additional space is needed, use bond paper. **Deleted pages** should be included in Block 8, but not in Block 7.

Block 9 - Subject of Amendment - Briefly describe plan material being transmitted.

Block 10 - Governor's Review - Check the appropriate box. See SMM section 13026 A.

Block 11 - Signature of State Agency Official - Authorized State official signs this block.

Block 12 - Typed Name - Type name of State official who signed block 11.

Block 13 - Title - Type title of State official who signed block 11.

Block 14 - Date Submitted - Enter the date that the state transmits plan material to CMCS. Unless the state officially withdraws this SPA and then resubmits it, this date should not be revised. Documentation of version revisions will be maintained in the CMCS administrative record.

Block 15 - Return To - Type the name and address of State official to whom this form should be returned.

Block 16–22 (FOR CMS USE ONLY).

Block 16 - Date Received - Enter the date plan material is received by CMCS. This is the date that the submission is received by CMCS via the subscribed submission process.

Block 17 - Date Approved - Enter the date CMCS approved the plan material.

Block 18 - Effective Date of Approved Material - Enter the date the plan material becomes effective. If more than one effective date, list each provision and its effective date in Block 22 or attach a sheet.

Block 19 - Signature of Approving Official - Approving official signs this block.

Block 20 - Typed Name of Approving Official - Type approving official's name.

Block 21 - Title of Approving Official - Type approving official's title.

Block 22 - Remarks - Use this block to reference and explain agreed to changes and strike-throughs to the original CMS-179 as submitted, a partial approval, more than one effective date, etc. If additional space is needed, use bond paper.

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

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

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

Provider-owned or controlled residential settings including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Reserved.

Reserved.

Reserved

Reserved.

Reserved.

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

Remote Support HBH Service Delivery Model

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

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

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

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

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

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

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

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

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

HBH Remote Support System Design

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Remote Support Service Requirements

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

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

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

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

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

HBH Remote Support Delivery Staff (Remote Support Professionals)

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

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

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

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

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

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

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

Backup On-Site HBH

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

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

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

Service Plan

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

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

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

Assessment

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

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

Informed Consent

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

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

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

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

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

Privacy

Remote Support Professionals must:

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

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

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

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

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

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

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

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

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

HBH delivered in a Host Home Service Requirements

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

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

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

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

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

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

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

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

2.) Enabling Technology for Remote Support

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

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

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

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

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

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

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

community employment. Day habilitation activities may include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quality Improvement Strategy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

			agencies, providers, participants, families, and other interested parties upon request.
	All service providers, case managers, care coordinators and MCO CBCMs, regardless of delivery system (i.e., FFS or managed care), are required to document major and minor incidents and make the incident reports and related documentation available to HHS upon request. Providers, case managers, and MCO CBCMs must also ensure cooperation in providing pertinent information regarding incidents as requested by HHS. MCOs must require that all internal staff and network providers report, respond to, and document critical incidents, as well as cooperate with any investigation conducted by the MCO or outside agency, all in accordance with State requirements for reporting incidents 1915(i) Habilitation Program and all other incidents required for licensure of programs through the Department of Inspections and Appeals. Per Chapter 441 Iowa Administrative Code 77.41(12), …"major incidents" are defined as an occurrence involving a member that is enrolled in an HCBS waiver, targeted case management, or habilitation services, and that: (1) results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital; (2) results in the death of any person; (3) requires emergency mental health treatment for the member; (4) requires the	Data is collected ongoing	HHS has oversight for monitoring incidents that affect all Habilitation participants. As part of the quality assurance policies and procedures for HCBS Habilitation remediated by the HCBS Incident Reporting Specialist and HCBS specialists. On a quarterly basis, a QA committee will review data collected on incidents and will analyze data to determine trends, problems and issues in service delivery and make recommendations of any policy changes. The HCBS QIO reviews all critical incident reports as soon as they are reported to HHS. All critical incidents are tracked in a critical incident database that tracks the date of the event, the specific HCBS program the member is enrolled in, the provider (if applicable), and the nature of the event, and follow up provided. If the incident has caused or is likely to cause a serious injury, impairment, or abuse to the member, and if Protective Services (PS) has completed or is in the process of conducting an investigation, the HCBS Specialist will coordinate with PS. If PS is not investigating, the HCBS Specialist will begin an on-site review within two working days of receipt of the report. If it is determined that the member has been removed from immediate jeopardy, the review is initiated with in twenty working

	intervention of law enforcement; (5) requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; (6) constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or (7) involves a member's location being unknown by provider staff who are assigned protective oversight. All major incidents must be reported by the end of the next calendar day after the incident has occurred using the Iowa Medicaid Portal Access (IMPA) System. Suspected abuse or neglect may be reported to the statewide abuse reporting hotline operated by HHS. Child and dependent adult abuse is an inclusive definition that includes physical and sexual abuse, neglect and exploitation. Child abuse is defined in Iowa Code 232.68, and may include any of the following types of acts of willful or negligent acts or omissions: - Any non-accidental physical injury. - Any mental injury to a child's intellectual or psychological capacity. - Commission of a sexual offense with or to a child.		days of receipt of report. For other non-jeopardy incidents, a review is initiated within twenty days. The HCBS QIO meets biweekly to review data tracked in the critical incident database and to decide if policy changes or additional training are needed. Data is compiled and analyzed in attempt to prevent future incidents through identification of system and provider specific training needs, and individual service plan revisions.

	- Failure on the part of a person responsible for the care of a child to provide adequate food, shelter, clothing or other care necessary for the child's health and welfare. - Presence of an illegal drug in a child's body as a direct act or omission of the person responsible for the care of a child or manufacturing of a dangerous substance in the presence of a child. Dependent adult abuse is defined in Iowa Code 235B.2, and may include any of the following types of acts of willful or negligent acts or omissions: - Physical injury or unreasonable confinement, unreasonable punishment, or assault of a dependent adult. - Commission of a sexual offense or sexual exploitation. - Exploitation of a dependent adult. - Deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care or other care necessary to maintain a dependent adult's life or health. When a major incident occurs, provider staff must notify the member or the member 's legal guardian within 24 hours of the incident and distribute a complete incident report form as follows:		

	- Forward a copy to the supervisor with 24 hours of the incident. - Send a copy of the report to the member's case manager or community-based case manager (when applicable) and the BLTC within 24 hours of the incident. - File a copy of the report in a centralized location and make a notation in the member's file. Per Chapter 441 Iowa Administrative Code 77.25(1), "minor incidents" are defined as an occurrence involving a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services, and that is not a major incident and that: (1) results in the application of basic first aid; (2) results in bruising; (3) results in seizure activity; (4) results in injury to self, to others, or to property; or (5) constitutes a prescription medication error. Providers are not required to report minor incidents to the BLTSS, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web-based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the		

	incident. The completed report must be maintained in a centralized file with a notation in the member's file. MCOs are also required to develop and implement a critical incident management system in accordance with HHS requirements, in addition to maintaining policies and procedures that address and respond to incidents, remediate the incidents to the individual level, report incidents to the appropriate entities per required timeframes, and track and analyze incidents. MCOs must adhere to the State's quality improvement strategy described in each HCBS waiver and waiver-specific methods for discovery and remediation. MCOs must utilize system information to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. All MCO staff and network providers are required to: - Report critical incidents. - Respond to critical incidents. - Document critical incidents.		

	- Cooperate with any investigation conducted by the HCBS QIO staff, MCO, or outside agency. - Receive and provide training on critical incident policies and procedures. - Be subject to corrective action as needed to ensure provider compliance with critical incident requirements. Finally, MCOs must identify and track critical incidents, and review and analyze critical incidents, to identify and address quality of care and/or health and safety issues, including a regular review of the number and types of incidents and findings from investigations. This data should be used to develop strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are responsible for developing and implementing critical incident management systems in accordance with the HHS requirements. Specifically, MCOs must maintain policies and procedures, subject to HHS review and approval, that: (1) address and respond to incidents; (2) report incidents to the appropriate entities per required timeframes; and (3) track and analyze incidents. This information is utilized to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop		

	and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. Training must be provided to all internal staff and network providers regarding the appropriate procedures for reporting, responding to, and documenting critical incidents. Network providers must provide training to direct care staff regarding the appropriate procedures for reporting, responding to, and documenting critical incidents. Finally, MCOs must identify and track, review and analyze critical incidents to identify and address quality of care and/or health and safety issues. MCOs must also regularly review the number and types of incidents and findings from investigations, in order to identify trends, patterns, and areas for improvement. Based on these findings, the MCO must develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. Consistent with 441 Iowa Administrative Code 77.41(12)c. the following process is followed when a major incident occurs or a staff member becomes aware of a major incident: (1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:		

	a. The staff member's supervisor. b. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to a guardian, if any, is always required. c. The member's case manager. (2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either: a. By direct data entry into the Iowa Medicaid Provider Access System, or b. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form. (3) The following information shall be reported:		

	a. The name of the member involved. b. The date and time the incident occurred. c. A description of the incident. d. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other individuals who were present must be maintained by the use of initials or other means e. The action that the provider staff took to manage the incident. f. The resolution of or follow-up to the incident. g. The date the report is made and the handwritten or electronic signature of the person making the report. If the critical incident involves the report of child or dependent adult abuse, it is mandatory that this type of critical incident is reported to HHS Protective Services. If the critical incident does not involve child or dependent adult abuse, it will be		

	reviewed by the MCO. The MCO will notify the member and/or the family of the results upon conclusion of the investigation, on or within 30 days.		
In accordance with 42 CFR 438.202, the State maintains a written strategy for assessing and improving the quality of services offered by MCOs including, but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries.	MCOs must comply with the standards established by the State and must provide all information and reporting necessary for the State to carry out its obligations for the State quality strategy. Iowa Medicaid performs an annual review of each MCO. This is generally conducted at the time of the annual External Quality Review (EQR) and includes a determination of contract compliance, including that for fraud and abuse reporting and training. EQR is performed as federally required, and committee reports are reviewed during an annual visit. The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the State and authenticated as it can be used during onsite visits and through regular reports.	Reviews are Conducted Annually	The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the state and authenticated as it can be used during onsite visits and through regular reports. The Medical Services Unit contractor conducts an annual EQR of each managed care entity to ensure that they are following the outlined QA/QI plan. In addition to developing QM/QI programs that include regular, ongoing assessment of services provided to Medicaid beneficiaries, MCOs must maintain a QM/QI Committee that includes medical, behavioral health, and long-term care staff, and network providers. This committee is responsible for analyzing and evaluating the result of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action, and ensuring appropriate follow-up. This committee is also responsible for reviewing and approving the MCOs' QM/QI program description, annual evaluation, and associated work plan prior to submission to HHS.

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

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

STATE PLAN UNDER TITLE XIX 0F THE SOCIAL SECURITY ACT

State/Territory: IOWA

STANDARDS AND METHODS TO ASSURE HIGH QUALITY CARE

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

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

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

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

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

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

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

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

☑	HCBS Enabling Technology for Remote Support
	For dates of service on or after November 1, 2023, providers shall be reimbursed at the amount authorized by the department or MCO through a quotation, contract, or invoice submitted by the provider.
☑	HCBS Day Habilitation
	For services provided on July 1, 2013 through December 31, 2013, day habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fees were set as of July 1, 2013 and are effective for dates of service provided on and after that date through December 31, 2013. For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home-based habilitation. The agency's fee schedule rate was set as of July 1, 2021 and is effective for services provided on or after that date. The rates for Day habilitation are located at 441 IAC 79.1(2) https://www.legis.iowa.gov/docs/iac/rule/07-05-2017.441.79.1.pdf
☐	HCBS Behavioral Habilitation
☐	HCBS Educational Services
☑	HCBS Prevocational Habilitation
	For services provided on July 1, 2013 through December 31, 2013, prevocational habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fees were set as of July 1, 2013 and are effective for dates of service provided on and after that date through December 31, 2013. For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home-based habilitation. The agency's fee schedule rate was set as of July 1, 2021 and is effective for services provided on or after that date. All rates are published on the agency's website at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule

☑	HCBS Supported Employment Habilitation
	For services provided on July 1, 2013 through December 31, 2013, supported employment habilitation services will be reimbursed according to the Iowa Plan for Behavioral Health contractor provider-specific cost based fee schedule rate without reconciliation. The Agency's fee schedule rate was set as of July 1, 2013 and is effective for dates of service provided on and after that date through December 31, 2013. For dates of services on or after January 1, 2014, providers shall be reimbursed a prospective statewide rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of supported employment habilitation. The agency's fee schedule rate was set as of July 1, 2021 and is effective for services provided on or after that date. All rates are published on the agency's website at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule