HOME Project Steering Committee - Meeting Summary

Tuesday, May 26, 2026, from 3:00 – 4:30 P.M. CT

Service Planning

Discussion: Service Planning and Member Experiences

The steering committee engaged in an in-depth discussion focused on person-centered service planning, current challenges within waiver systems, and opportunities to improve consistency, transparency, and outcomes for members. HHS opened the meeting by reviewing federal requirements for person-centered planning and explaining the department's intention to develop a universal service plan to standardize processes across programs.

Key themes included:

• Persistent concerns that assessments and service authorizations do not reflect actual need, particularly for members with intensive physical disabilities who require skilled care and flexible support arrangements.
• Reports of reduced budgets, denials, or cuts to longstanding services, often without clear explanation or in contradiction to the assessment results.
• Frustration with case management inconsistencies, including limited knowledge of available services, insufficient training, and significant variation across MCOs and fee-for-service processes.
• The emotional and physical toll on families who must appeal decisions annually, despite stable or increasing needs.
• Concerns that some service reductions are driven by funding limitations rather than assessed need, undermining trust in the process.
• Experiences of members being told certain services are unavailable due to categorical rules (e.g., community activities denied because they are considered "job services").
• Challenges identifying or maintaining adequate staffing due to workforce shortages, resulting in underutilization of authorized hours and subsequent reductions.
• The need for greater flexibility to carry over unused SCL, respite, or other services within a quarter when staffing gaps—not decreased need—prevent full usage.
• Concerns about back-to-back scheduling of assessments and planning meetings, which prevents case managers and families from fully considering the assessment results before writing a plan.
• Requests for planning processes that do not require members to re-explain stable, permanent conditions every year.
• Provider concerns that service plans often default to the most expensive levels of care

because the “right service” (e.g., respite) is unavailable, ultimately costing more and worsening outcomes

Additional issues raised:
• Difficulty navigating medical reviews or unexplained eligibility decisions made outside of the case manager’s knowledge.
• Inconsistent use of signatures, with some MCO systems not clearly dictating if they are collecting meeting attendance through signatures or signifying plan approval.
• Confusion over how and when members receive final copies of their plans—and whether those plans match what was discussed.
• A need for better alignment between rights restrictions and required behavioral support documentation to ensure compliance.

Universal Service Plan Design

HHS requested feedback on what should be included or improved within a future universal service plan.

Participants emphasized the following priorities:
• Clear guidance and prompts to support case managers in writing accurate, individualized goals—particularly for SCL and newer services.
• Consistency across MCOs and fee-for-service to reduce confusion, duplicated work, and contradictory requirements.
• A simplified structure that avoids overly narrow drop-down choices, ensures room for individualized needs, and streamlines documentation for stable conditions.
• Improved emergency backup sections, especially for individuals without natural supports, including options for supplemental funds, backup staffing, or integration with home health.
• Reducing redundancy by allowing case managers direct access to medical records when possible, rather than repeatedly collecting the same information.
• Clearer documentation requirements for rights restrictions to ensure all necessary components (e.g., behavioral plans) are included.
• Better capture of systemic gaps—such as lack of respite or rural provider shortages—so the state can identify patterns and address root causes.

Overall, members supported the idea of a universal service plan but stressed the importance of flexibility, clarity, and reducing administrative burden.

Communications and Engagement Updates

HHS presented new strategies to improve communication throughout the HOME project and waiver transition.

Key updates included:

• Development of a redesigned HOME project webpage with simpler navigation, “quick links,” and user specific sections for members, providers, case managers, and stakeholders.
• Creation of a centralized “News and Announcements” page with regularly updated information in chronological order.
• Plans for short instructional videos explaining waiver transitions, available both on the website and through social media.
• A shift toward monthly newsletters as implementation approaches.
• Expanded use of the Iowa Medicaid Facebook page and LinkedIn to share updates more broadly.
• Improved accessibility through options such as translated materials, simplified summaries, screen reader compatible formats, and Spanish language video dubbing.

Participants offered suggestions to strengthen communication:

• Keep videos short and focused, with transcripts or companion summaries.
• Use social media platforms—especially those already frequented by younger or more tech savvy users—to increase reach.
• Consider partnering with individuals with disabilities or community influencers to deliver messages in more relatable, engaging formats.
• Ensure materials are clear, audience specific, and avoid overwhelming readers with system focused language.

Follow-up Items and Clarifications

HHS provided updates on several earlier questions submitted by the committee:

• Reopening public comment will not delay HOME implementation; CMS requires only a 90day review period.
• Most funding tiers align with current structures; mitigation is being explored for members affected by nursing caps in the AIDS/HIV waiver.
• SCL will not be included in monthly cost caps once introduced in Phase 2.
• Members may access Phase 2 services (including SCL) as soon as Phase 2 is implemented.
• Provider qualification requirements can be found in Appendix C of the waiver.
• HHS is developing mitigation strategies for service gaps affecting children and youth, especially around attendant care.
• Transition to the new Adult with Disabilities waiver will occur for all members on the go

live date, not at annual reviews.
• Case managers are responsible for reviewing assessment results with families and should provide the family friendly summary.
• Tier changes cannot occur based on off year assessments alone.
• A new assessment vendor will begin work in July; more details will be shared at the next meeting.
• Additional topics suggested for future meetings include fiscal intermediary changes for CCO and timing of service years under the new waiver structure.

Overall Takeaways

The steering committee reinforced several overarching priorities:

- Increase clarity, transparency, and usability of information.
- Provide concrete examples to demonstrate real-world impact.
- Improve communication strategies to reach broader and more diverse audiences.
- Address systemic challenges that may affect implementation.
- Ensure stakeholders feel heard and that their input contributes meaningfully to outcomes.

The next HOME Project Steering Committee Meeting will be held on **Tuesday, June 30th, 2026, from 3:00pm-4:30pm CT.**