

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Physical)		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Other)		<input type="checkbox"/>	<input type="checkbox"/>
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury		<input type="checkbox"/>	<input type="checkbox"/>
		HIV/AIDS	0	<input type="checkbox"/>	<input type="checkbox"/>
		Medically Fragile		<input type="checkbox"/>	<input type="checkbox"/>
		Technology Dependent		<input type="checkbox"/>	<input type="checkbox"/>
Intellectual Disability or Developmental Disability, or Both					
		Autism		<input type="checkbox"/>	<input type="checkbox"/>
		Developmental Disability		<input type="checkbox"/>	<input type="checkbox"/>
		Intellectual Disability		<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness					
		Mental Illness		<input type="checkbox"/>	<input type="checkbox"/>
		Serious Emotional Disturbance		<input type="checkbox"/>	<input type="checkbox"/>

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

Per 441 Iowa Administrative Code 83.42(1) individuals must be diagnosed by a physician as having AIDS or HIV infection.

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

Not applicable. There is no maximum age limit

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

Specify:

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

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

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

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

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (*select one*)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

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

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

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

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

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

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

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

Other safeguard(s)

Specify:

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

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the

number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	35
Year 2	36
Year 3	42
Year 4	46
Year 5	50

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

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	[]
Year 2	[]
Year 3	[]
Year 4	[]
Year 5	[]

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

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

Not applicable. The state does not reserve capacity.

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

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

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the state may make the number of participants who are served

subject to a phase-in or phase-out schedule (*select one*):

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

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

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

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

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

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

Individuals are accepted into the AIDS/HIV waiver on a first come first served basis based on the date of application. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) are followed. The AIDS/HIV waiver does not have administrative rules to establish a waiting list for services. All eligible applicants will be issued a funding slot for services.

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

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

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B-4: Eligibility Groups Served in the Waiver

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

§1634 State

SSI Criteria State

209(b) State

2. Miller Trust State.

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

No

Yes

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

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

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

SSI recipients

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

Optional state supplement recipients

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

Select one:

100% of the Federal poverty level (FPL)

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

Specify percentage:

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

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

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

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

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

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

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

Specify:

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

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

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

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

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

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

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

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

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

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

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

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

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

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B-5: Post-Eligibility Treatment of Income (2 of 7)

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

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

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

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

1. Determine only the member’s total gross monthly income.
2. Subtract a maintenance needs allowance of 300% of the current SSI benefit for one person.
3. For participants who have a medical assistance income trust (Miller Trust) subtract:
 - a. an additional \$10 for trustee fee
 - b. A deduction for spouse and/or dependent needs
4. Add in veteran’s aid and attendance, house-bound allowance, or other third-party payments not counted as income for eligibility.

The result is the client participation amount.

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

300% of the SSI benefit and for participants who have a medical assistance income trust (Miller Trust) an additional \$10 (or higher if court ordered) to pay for administrative costs.

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

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

The result is the client participation amount.

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

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

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

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

Select one:

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

The state does not establish reasonable limits.

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is

deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

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

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B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

The provision of waiver services at least monthly

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

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

HCBS waiver services must be accessed at least once every calendar quarter by the member.

As part of the AIDS/HIV waiver service, case management is required for each participant, regardless of delivery system. Case managers and community-based case managers are required to make monthly contacts, either face to face or telephonic, regarding each member in order to establish access to services and to ensure the authorized services are provided as outlined in the participant's service plan to ensure the participant's health, safety and welfare. Case managers and community-based case managers are additionally required to make face-to-face contact with the member once per quarter.

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

Iowa Medicaid Medical Services Unit (MSU) is responsible for making all initial level of care decisions. If a member is not currently on Medicaid or is in Medicaid fee-for-service (FFS), the Iowa Medicaid's Core Standardized Assessment (CSA) contractor performs the assessment. If a member is enrolled with a MCO, the initial assessment is performed by the MCO, but the Iowa Medicaid Medical Services unit conducts the initial LOC determination. LOC decisions also include input from the case manager, community-based case manager, medical professional, and other appropriate professionals.

For FFS members, the annual LOC reevaluation is conducted by the Iowa Medicaid MSU. MCOs are responsible for annual LOC reevaluations of their members. The Iowa Medicaid MSU reviews and approves all MCO reevaluations that indicate a change in the member's level of care. MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services.

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

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

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

Iowa Medicaid Medical Services uses the following assessments to evaluate and reevaluate applicants and members:
 Ages 0 – 3 Case Management (CM) Comprehensive Assessment
 Ages 4 -20 interRAI – Pediatric Home Care (PEDS-HC)
 Ages 21 and older interRAI – Home Care (HC)

CM Comprehensive Assessment

This is the previous tool used for level of care determination prior to the implementation of the interRAI tools for the age groups listed above. The interRAI did not offer a tool for the age group from 0-3; therefore, the CM Comprehensive Assessment continues to be used for infants and children through age 3.

This assessment tool used is based on the *Minimum Data Set (MDS), the individual requires supervision, or limited assistance, provided on a daily basis by the physical assistance of at least one person, for dressing and personal hygiene activities of daily living as defined by the minimum data set section G, entitled Physical Functioning and Structural Problems

There is not a scoring system, but based on the MDS, the individual requires the establishment of a safe, secure environment due to modified independence (some difficulty in new situations only) or moderate impairment (decisions poor, cues and supervision required; never or rarely made a decision; danger to self or others) of cognitive skills for daily decision making. The following areas are assessed: (1) cognitive, mood and behavior patterns; (2) physical functioning-mobility; (3) skin condition; (4) pulmonary status; (5) continence; (6) dressing and personal hygiene; (7) nutrition; (8) nutrition; (9) medications; (10) communication; (11) psycho-social

interRAI – Home Care Assessments

The interRAI Home Care Assessment System (HC) has been designed to be a user-friendly, reliable, person-centered assessment system that informs and guides comprehensive care and service planning in community-based settings around the world. It focuses on the person's functioning and quality of life by assessing needs, strengths, and preferences, and facilitates referrals when appropriate. When used over time, it provides the basis for an outcome-based assessment of the person's response to care or services. The interRAI HC can be used to assess adults with chronic needs for care as well as those with post-acute care needs (for example, after hospitalization or in a hospital-at-home situation). The PEDS-HC instrument is designed to be used to assess the home care challenges of children and youths ranging in age from 4 through 20 who are seeking or receiving long-term services or supports. Areas of interRAI review include: (1) cognitive; (2) mood and behavior patterns; (3) physical functioning – mobility; (4) skin condition; (5) pulmonary status; (6) continence; (7) dressing and personal hygiene – ADLS; (8) physical functioning – eating; (9) medications; (10) communication/hearing/vision patterns; and (11) prior living - psychosocial. The interRAI HC and the interRAI PEDS-HC instruments assess the same areas of need.

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

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

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

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

The interRAI HC Assessment Form is a Minimum Data Set screening tool that enables a trained assessor to assess multiple key domains of function, health, social support and service use. Particular interRAI HC items also identify persons who could benefit from further evaluation of specific problems or risks for functional decline. These are triggers that link the interRAI HC to a Clinical Assessment Protocol (CAP). The CAPs contain general guidelines for further assessment.

The HC system supports a variety of research-informed decision support tools that assist the assessor in planning and monitoring care. These include:

- *Scales for ADLs, cognition, communication, pain, depression, and medical instability

- *Clinical Assessment Protocols that contain strategies to address problem conditions as triggered by one or more HC item responses

- *Screening systems to identify appropriate outreach and care pathways for prospective clients (the MI Choice and MAPLe systems)

- *A quality monitoring system (Home Care Quality Indicators, or HCQIs)

- *A case-mix system that creates distinct service-use intensity categories (RUG-III/HC)

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

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

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

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

MCOs are responsible for conducting LOC reevaluations for members, using DHS designated tools, at least annually, and when the MCO becomes aware that the member's functional or medical status has changed in a way that may affect LOC eligibility. Additionally, any member or provider can request a reevaluation at any time. Once the reevaluation is complete, the MCO submits the LOC or functional eligibility information to the MSU. The State retains authority for determining Medicaid categorical, financial, LOC or needs-based eligibility and enrolling members into a Medicaid eligibility category. MCOs track and report LOC and needs-based eligibility reevaluation data, including, but not limited to, reevaluation completion date. MCOs are required to notify DHS of any change in LOC and DHS retains final LOC determination authority. As the State is a neutral third party with final approval authority, there is no conflict of interest. MCOs are contractually required to develop and maintain their own electronic community-based case management systems that include functionality to ensure compliance with the State's 1915(c) HCBS waiver and law. This includes, but is not limited to, the ability to capture and track: (i) key dates and timeframes such as enrollment date, date of development of the care plan, date of care plan authorization, date of initial service delivery, date of level of care and needs reassessments and dates of care plan updates and the functionality to notify the community-based case manager or care coordinator of care plan, assessment and reassessment deadlines; (ii) the care plan; (iii) all referrals; (iv) level of care assessment and reassessments; (v) needs assessments and reassessments; (vi) service delivery against authorized services and providers; (vii) actions taken by the community-based case manager or care coordinator to address service gaps; and (viii) case notes.

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

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

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

The qualifications are different.

Specify the qualifications:

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

FFS

The FFS CSA contractor is responsible for submitting timely LOC reevaluations of members. Reevaluations are considered timely if they are completed within twelve (12) months of the previous evaluation. Reevaluations of FFS members are tracked in the Institutional and Waiver Authorization and Narrative System (IoWANS). An IoWANS milestone is sent out to the FFS CSA contractor 60 days before the reevaluation is due.

On a weekly basis, an IoWANS CSR report is extracted to identify FFS overdue reevaluations. The list is sent to the management team for HHSCSA management for resolution. The hHS CSA management submits a weekly status report to the designated HCBS program manager for monitoring with conferencing as needed.

A CSR or re-evaluation report is also available through IoWANS to track overdue reevaluations and is monitored by Iowa Medicaid.

MCO

Reevaluations of MCO members are also tracked in the Institutional and Waiver Authorization and Narrative System (IoWANS) for Iowa Medicaid oversight. However, MCOs are also responsible for recording timely completion of LOC reevaluations of members. One hundred percent (100%) of member LOC reevaluations must be completed within twelve (12) months of the previous evaluation. IoWANS is queried weekly to monitor the status of MCO LOC determinations. Iowa Medicaid shares this information is shared with MCOs and the MCO account managers. HHS reserves the right to audit MCO application of LOC criteria to ensure accuracy and appropriateness.

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

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

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

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

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

LC-a1: Number and percent of referrals for LOC that received a completed LOC decision. Numerator: # of referrals for LOC that received a completed LOC decision; Denominator: # of referrals for LOC.

Data Source (Select one):

Other

If 'Other' is selected, specify:

FFS and MCO members will be pulled from IoWANS for this measure. Iowa Medicaid MSU completes all initial level of care determinations for both FFS and MCO populations.

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

<p>Other Specify:</p> <input type="text" value="contracted entity"/>	<p>Annually</p>	<p>Stratified Describe Group:</p> <input type="text"/>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <input type="text"/>
	<p>Other Specify:</p> <input type="text"/>	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

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

Performance Measures

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

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

Performance Measure:

LC-c1: Number and percent of initial level of care decisions that were accurately determined by applying the approved LOC criterion using standard operating procedures. Numerator: # of initial LOC decisions that were accurately determined by applying the approved LOC criterion using standard operating procedures; Denominator: # of reviewed initial LOC determinations

Data Source (Select one):

Other

If 'Other' is selected, specify:

Iowa Medicaid MQIDS and OnBase

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;">+/- 5% with 95% confidence level</div>
Other	Annually	Stratified

<p>Specify:</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px 0;">Contracted Entity</div>		<p>Describe Group:</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px 0;"> IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%) </div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p>

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input style="width: 100%; height: 20px;" type="text"/>

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

Data for completed LOC is collected quarterly through reports generated through ISIS, MQUIDS, and OnBase. This data is monitored for trends from an individual and systems perspective.

Monthly a random sample of LOC decisions is selected from each reviewer. Internal Quality Control activity is completed on the random sample. This level of scrutiny aids in early detection of variance from the stated LOC criteria.

b. Methods for Remediation/Fixing Individual Problems

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

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

When an eligibility approval is made in error, the State allows for timely notice and discontinues the participant's benefits. All payments that were made for services, in which the participant was not actually eligible for, are deemed as an error and an overpayment is set to be collected from the participant. The eligibility worker reaches out to the participant at that time, explains to them what happened and encourages them to not use any additional services that will need to be repaid. If the participant is only eligible due to being eligible for the waiver, all Medicaid and waiver payments will be subject to the overpayment. If the participant is eligible for Medicaid on their own right, then only the waiver services are subject to the overpayment recoupment.

ii. **Remediation Data Aggregation**

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

FFS

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

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

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

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

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

MCO

MCO community-based case managers are required ensure that members are offered choice according to their respective MCO processes and forms, which are reviewed and approved by HHS. The MCOs provide oversight of service planning by reviewing the person centered service plan to determine if choice between waiver and institutional care has been provided and provider choice is offered. During the IPES member telephone surveys, the MCO asks members if they are offered choice of providers.

In addition, Iowa Medicaid QIO reviews the person centered service plan to determine if provider choice (including CCO) is offered.

The HCBS QIO Unit, during the IPES member telephone surveys, asks members if they are offered choice of providers.

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

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

FFS

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

MCO

MCOs are responsible for maintaining records that fully disclose the extent of services provided to members for a minimum of seven years and must furnish such information to duly authorized and identified agents or representatives of the state and federal governments. The MCOs maintain copies of freedom of choice forms in the MCO database and the member's electronic health record.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

- MCOs must conform to HHS policies regarding meaningful access to the waiver by limited English proficient persons, and to deliver culturally competent services in accordance with 42 CFR 438.206.
- MCOs must provide language services at no cost to limited English proficiency members, and all written materials shall be provided in English and Spanish, as well as any additional prevalent languages identified by the State or through an analysis of member enrollment (i.e., any language spoken by at least five percent (5%) of the general population in the MCO's service area).
- MCOs must provide oral interpretation services free of charge to each member (this applies to all non-English languages, and is not limited to prevalent languages), and MCOs must notify all members that oral interpretation and translated written information is available and how to access those services. Written materials must include taglines in prevalent languages regarding how to access materials in alternative languages.
- MCOs must ensure that service plans reflect cultural considerations of the member and that service plan development is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b).
- MCOs must operate member services helplines that are available to all callers, and an automated telephone menu options must be made available in English and Spanish.
- MCOs must maintain member websites and mobile applications available in English and Spanish that are accessible and functional via cell phone.

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