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State/Territory Name: IA

State Plan Amendment (SPA) #: 13-017

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

May 2, 2014

Charles M. Palmer, Director
Department of Human Services
Hoover State Office Building
1305 East Walnut, 5th Floor
Des Moines, Iowa 50319-0119

Dear Mr. Palmer:

The Centers for Medicare & Medicaid Services (CMS), Kansas City Regional Office, has completed its review of Iowa State Plan Amendment (SPA) Transmittal Number 13-017.

This SPA amends the areas of the state that targeted case management (TCM) is provided effective January 1, 2104, to all counties except Polk, Warren, Dubuque, Linn, and Woodbury. Effective October 1, 2014, TCM will be provided in all counties except Polk, Warren, Dubuque, Linn, Woodbury, Benton, Black Hawk, Buchannan, Calhoun, Cedar, Cerro Gordo, Clinton, Delaware, Floyd, Grundy, Hancock, Harrison, Humboldt, Iowa, Jackson, Johnson, Jones, Kossuth, Mills, Mitchell, Muscatine, Pocahontas, Pottawattamie, Scott, Webster, Winnebago, Worth and Wright counties.

In addition, this amendment reflects the delivery of 1915(i) home and community based services (HCBS) in accordance with number one of the special terms and conditions as authorized under Iowa's 1915(b) waiver IA-97.R06, effective July 1, 2013. This amendment revises the performance measures to include measures on quality of life and community integration reflecting the prepaid inpatient health plan (PIHP) delivery system; includes assurances that under managed care the independent assessment and person-centered service planning and coordination is done in conjunction with the beneficiary by an entity that acts independently and free from any conflict of interest; and includes safeguards as to how conflict of interest problems will be avoided.

Finally, the SPA modifies the reimbursement for TCM services by applying a limit on programmatic indirect and overhead costs.

This SPA is approved May 1, 2014, with an effective date of July 1, 2013. Enclosed is a copy of the CMS 179 form, as well as, the approved pages for incorporation into the Iowa State plan.

If you have any questions regarding this state plan amendment, please contact Narinder Singh or Sandra Levels at (816) 426-5925.

Sincerely,

//s//

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Enclosure

cc: Jennifer H. Vermeer
LeAnn Moskowitz
Alisa Horn

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: 13 — 017

2. STATE: IOWA

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION

7. FEDERAL BUDGET IMPACT
a. FFY '13 $ (93,723)
b. FFY '14 $ (1,097,034)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Supplement 2 to Attachment 3.1-A, Page 38 & 38b *
Attachment 3.1-C, Pages 3, 4, 5, 6, 9, 10, 11, 14, 15, 21, 22, 23, 24, 25, 26
Attachment 4.19-B, Pages 17, 18, 19, ~~20,~~ 20b *
* Attachment 3.1-C, Pages 1, 2, 7, 8, 11b, 12, 13, 16, 17, 18, 19, 20 20b - 20j, 26b - 26o

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Supplement 2 to Attachment 3.1-A, Page 38
Attachment 3.1-C, Pages 3, 4, 5, 6, 9, 10, 11, 14, 15, 21, 22, 23, 24, 25, 26
Attachment 4.19-B, Pages 17, 18, 19, ~~20,~~ ~~and new page 20b~~ *
Attachment 3.1-C Pages 1, 2, 7, 8, 12, 13, 16, 17, 18, 19, 20 *

10. SUBJECT OF AMENDMENT

Change areas in which TCM will be provided effective 1/1/14^ and 10/1/14 move administration of the 1915(i) program to the Iowa Plan for Behavioral Health. Continues transition of Medicaid funded mental health services to the Iowa Plan for Behavioral Health.

11. 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

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME: CHARLES M. PALMER

14. TITLE: DIRECTOR

15. DATE SUBMITTED: 8-21-13

16. RETURN TO

CHARLES M. PALMER
DIRECTOR
DEPARTMENT OF HUMAN SERVICES
1305 EAST WALNUT 5TH FLOOR
DES MOINES IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: August 21, 2013

18. DATE APPROVED: May 1, 2014

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2013

20. SIGNATURE OF REGIONAL OFFICIAL: //s//

21. TYPED NAME: James G. Scott

22. TITLE: Associate Regional Administrator for Medicaid and Children's Health Operations

23. REMARKS

* Per Pen and Ink request received from state via e-mail dated 4.24.14

FORM CMS-179 (07/92)

Instructions on Back

Revised Submission 2.6.14

State Plan under Title XIX of the Social Security Act
State/Territory: IOWA

TARGETED CASE MANAGEMENT SERVICES
Target Group 1

_X_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 60 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

__ Entire State
_X__ Only in the following geographic areas:

Effective January 1, 2014, all counties except Polk Warren Dubuque Linn, and Woodbury counties.

Effective October 1, 2014 all counties except Polk Warren Dubuque Linn, Woodbury, and Benton Black Hawk Buchanan Calhoun Cedar Cerro Gordo Clinton Delaware Floyd Grundy Hancock Harrison Humboldt Iowa Jackson Johnson Jones Kossuth Mills Mitchell Muscatine Pocahontas Pottawattamie Scott Webster Winnebago Worth and Wright counties

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

_X_ Services are provided in accordance with §1902(a)(10)(B) of the Act.
___ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
  - A face-to-face assessment must be conducted at a minimum annually and more frequently if changes occur in the individual's condition.
- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

Revised Submission 2.6.14

State Plan under Title XIX of the Social Security Act
State/Territory: IOWA

TARGETED CASE MANAGEMENT SERVICES
Target Group 1

- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual;

❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including

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

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

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

HCBS Habilitation Services: 1915(i) HCBS State Plan Program

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

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

3. **Distribution of State plan HCBS Operational and Administrative Functions.**

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

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

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

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

1. Individuals are assisted with enrolling in the state plan HCBS Habilitation services through the Iowa Medicaid Enterprise's Iowa Plan for Behavioral Health Contractor, the case manager or integrated health home care coordinator.
2. Iowa does not limit the number of enrollees.
3. The Department of Human Services' Income Maintenance Workers determines if the member is eligible for Medicaid and determines the member's income level.
4. The Iowa Medicaid Enterprise's Medical Services Unit determines if the member meets the needs based criteria also referred to as the non-financial criteria for enrollment in state plan HCBS.
5. Service plan review is primarily carried out by the Iowa Medicaid Enterprise's Iowa Plan for Behavioral Health contractor. This function is also carried out by the Iowa Medicaid Enterprise's contractor for medical services or Policy staff.
6. Recommendation for prior authorization is primarily done by the Iowa Medicaid Enterprise's Iowa Plan for Behavioral Health contractor, through the service plan review process. This function may also be completed by Iowa Medicaid Enterprise policy staff.
7. Utilization management functions are set by Iowa Medicaid Enterprise policy staff and primarily carried out by the Iowa Medicaid Enterprise's Iowa Plan for Behavioral Health contractor. Needs-based eligibility criteria are determined by Iowa Medicaid Enterprise policy staff. The Iowa Medicaid Enterprise's Iowa Plan for Behavioral Health contractor reviews the needs-based evaluation to ensure the member meets the needs-based eligibility criteria. Parameters for prior authorization are determined by Iowa Medicaid Enterprise policy staff, Iowa Medicaid Enterprise's Iowa Plan for Behavioral Health contractor service authorization system reviews and authorizes treatment plan data
8. Recruitment of providers may be done by Iowa Medicaid Enterprise policy staff or by the Iowa Medicaid Enterprise's Iowa Plan for Behavioral Health contractor.
9. Execution of the provider agreement is primarily done by the Iowa Medicaid-Enterprise's Iowa Plan for Behavioral Health contractor on behalf of the Iowa Medicaid Enterprise. The provider agreement has been written by Iowa Medicaid Enterprise staff in conjunction with the Iowa Attorney General's office.
10. Establishment of a consistent rate is done by the Iowa Medicaid Enterprise's Iowa Plan for Behavioral Health contractor with the participation by Iowa Medicaid Enterprise policy staff
11. Training and technical assistance is overseen by Iowa Medicaid Enterprise policy staff and primarily implemented by the Iowa Medicaid Enterprise's HCBS quality assurance and improvement contractor. The Iowa Plan for Behavioral Health contractor and the Iowa Medicaid Enterprise policy staff also conduct training as needed.
12. Quality monitoring is overseen primarily by Iowa Medicaid Enterprise policy staff and primarily implemented by the Iowa Medicaid Enterprise's HCBS quality assurance and improvement contractor. The Iowa Medicaid Enterprise's Iowa Plan for Behavioral Health contractor also maintains a quality assurance monitoring system for the Habilitation service provider network.

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

4. ☑ **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual

- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

The Integrated Health Home Care Coordinator or Targeted Case Manager completes the comprehensive functional assessment and then submits the assessment to the Iowa Medicaid Enterprise's Medical Services Unit contractor, Telligen, for needs-based criteria eligibility determination for state plan HCBS. The IME's Medical Services Unit also predetermines non-financial eligibility on an annual basis.

Final determinations regarding eligibility, assessment, and person-centered service plans are made by the Iowa State Medicaid Agency.

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

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

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

Number Served

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

Annual Period	From	To	Projected Number of Participants
Year 1	07/01/2013	06/30/2014	5,318
Year 2	07/01/2014	06/30/2015	5,716
Year 3	07/01/2015	06/30/2016	6,143
Year 4	07/01/2016	06/30/2017	6,602
Year 5	07/01/2017	06/30/2018	7,095

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

Financial Eligibility

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

2. **Income Limits.**

☐ In addition to providing State plan HCBS to individuals described in item 1 above the State is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for home and community-based services under the needs-based criteria established under 1915(i)(1)(A) or who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d), (e), or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income federal benefit rate. (*Select one*):

☐ The State covers all of the individuals described in item 2(a) and (b) as described below. (*Complete 2(a) and 2(b)*)

☐ The State covers only the following group of individuals described below. (*Complete 2(a) or 2(b)*)

2. (a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria for the 1915(i) benefit, have income that does not exceed 150% of the federal poverty line, and will receive 1915(i) State plan HCBS.

Methodology used (*Select one*):

☐ AFDC
☐ SSI
☐ OTHER (*Describe*):

For States that have elected the AFDC or the SSI methodology, the State uses the following less restrictive 1902(r) (2) income disregards for this group. There is no resource test for this group. (*Specify*):

2.(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d), (e), or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income federal benefit rate. For individuals eligible for 1915(c), (d), or (e) waiver services, this amount must be the same amount as the income standard specified under your State plan for the special income level group. For individuals eligible for 1915(c)-like services under an approved 1115, this amount must be the same as the amount of the income standard used for individuals found eligible using institutional eligibility rules. (*Select one*):

☐ 300% of the SSI/FBR
☐ (*Specify*) _____% Less than 300% of the SSI/FBR

(*Select one*):
☐ Specify the 1915(c) waiver/waivers CMS base control number/numbers for which the individual would be eligible: ___

☐ Specify the name(s) or number(s) of the 1115 waiver(s) for which the individual would be eligible:

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

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

Evaluation/Reevaluation of Eligibility

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

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

The Iowa Medicaid Enterprise provides financial eligibly data daily to the Iowa Plan contractor. A member requesting Habilitation services under the Iowa Plan for Behavioral Health must be Medicaid eligible and have income that does not exceed 150% FPL.

The Comprehensive Functional Assessment to determine if the member meets the needs based criteria for services is completed by either a Case Manager (CM) or an Integrated Health Home Coordinator (IHHCC).

The assessment is submitted to the Iowa Medicaid Enterprise's Medical Services Unit for approval of non-financial eligibility state plan HCBS. Iowa Medicaid Enterprise's Medical Services Unit contractor is responsible for annual approval.

If the member meets the criteria, Habilitation is approved and the Iowa Plan Contractor is notified. The CM or IHHCC coordinates the interdisciplinary team meeting to develop the service plan. Once developed the service plan is submitted to the Iowa Plan contractor for Iowa Plan enrollees, or the Medical Services Unit for members not eligible for the Iowa Plan for service authorization.

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

The direct service provider submits the claim for service to the Iowa Plan contractor for Iowa Plan enrollees, or to the Iowa Medicaid Enterprise for payment members not eligible for the Iowa Plan

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

The Iowa Plan for Behavioral Health contractor requires that the individuals performing evaluations must be:

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

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

The Iowa Plan for Behavioral Health contractor has established a process for reviewing treatment plans and authorizing units of services. Contractor staff communicates by phone with the case manager or Integrated Health Home Coordinator to discuss the member's assessment and needs for service. A determination is made by the contractor for the appropriate services and units based on the assessment, treatment plan and other services the member may be receiving

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

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

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

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

- Has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care, more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization). Individuals currently undergoing inpatient hospitalization demonstrate this risk factor, but cannot receive 1915(i) HCBS State Plan Services while in an institution, including hospitals.
- Has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

In addition, the person has a need for assistance typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

- Is unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
- Requires financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
- Shows severe inability to establish or maintain a personal social support system.
- Requires help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management.
- Exhibits inappropriate social behavior that results in demand for intervention.

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

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

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
The individual meets at least one of the following risk factors: o Has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care, more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization). Individuals currently undergoing inpatient hospitalization demonstrate this risk factor, but cannot receive 1915(i) HCBS State Plan Services while in an institution, including hospitals. o Has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization. --AND-- Has a need for assistance typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years: o Is unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history. o Requires financial	Based on the Minimum Data Set (MDS) section G, 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 –OR— 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: o Cognitive, Mood and behavior patterns o Physical functioning-Mobility o Skin condition o Pulmonary Status o Continence o Dressing and Personal Hygiene (ADL's) o Nutrition o Medications o Communication o Psycho-social	1. A diagnosis of mental retardation before 18 years of age as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or a related condition as defined by the Code of Federal Regulations 41 CFR 435.1009. --AND-- 2. Three or more deficits resulting in substantial functional limitation in major life activity areas as defined in 42 CFR 435.1009(d): o Self-care o Understanding and use of language o Learning o Mobility o Self Direction o Capacity for independent living	**Mental Status:** A. Need for 24-hour professional observation, evaluation and/or diagnosis of a patient exhibiting behaviors consistent with acute psychiatric disorder, which may include significant mental status changes. B. Documented failure of current outpatient treatment including two or more of the following necessitating 24 hour professional observation supported by medical record documentation: o exacerbation of symptoms o noncompliance with medication regimen o lack of therapeutic response to medication o acute neuroleptic reaction o psychotropic or neuroleptic medication toxicity o lack of patient participation in the outpatient treatment program Information regarding prior hospitalizations and length of stay will be obtained as well as evaluation of the patient's medical stability to participate in a comprehensive treatment plan.

assistance for out-of-hospital maintenance and may be unable to procure this assistance without help. o Shows severe inability to establish or maintain a personal social support system. o Requires help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management. o Exhibits inappropriate social behavior that results in demand for intervention.			

*Long Term Care/Chronic Care Hospital

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

The state does not intend to target a population. Members who meet the needs based and risk based criteria in addition to the income eligibility, are eligible to receive services.

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

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

9. ☑ **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health related treatment or support services, if such residence meets standards for community living as defined by the State and approved by CMS. (If applicable, specify any residential settings, other than an individual's home or apartment, in which 1915(i) participants will reside. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):

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

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

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

a) The setting is integrated in, and facilitates the individual's full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, like individuals without disabilities;
b) The setting is selected by the individual among all available alternatives and identified in the person-centered service plan;
c) An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
d) Individual initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented; and
e) Individual choice regarding services and supports, and who provides them, is facilitated.
f) The setting is integrated in, and facilitates the individual's full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, like individuals without disabilities;
g) 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.
h) 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.
i) Each individual has privacy in their sleeping or living unit
j) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
k) Individuals sharing units have a choice of roommates in that setting.
l) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
m) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
n) Individuals are able to have visitors of their choosing at any time.
o) The setting is physically accessible to the individual.

For 1915(i) State plan home and community-based services, settings that are not home and community-based are defined at §441.710(a)(2) as follows: A nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting, as determined by the Secretary.

Setting Requirements

In accordance with the state's transition planning requirements to be effective on the date approved by CMS, Home Based Habilitation 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.

Person-Centered Planning & Service Delivery

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

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
   - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
   - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
   - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
   - An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
   - If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
   - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
2. ☑Based on the independent assessment, the individualized plan of care:
   - Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
   - Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
   - Prevents the provision of unnecessary or inappropriate care;
   - Identifies the State plan HCBS that the individual is assessed to need;
   - Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
   - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
   - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.
3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualification.)*

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

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

4. **Responsibility for Plan of Care Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

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

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

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

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

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

(c) The Case Manager or Integrated Health Home Care Coordinator must ensure that the service planning process:

a) Occurs at times and locations convenient to the participant
b) Reflects cultural consideration of the individual
c) Includes strategies for solving conflict or disagreement within the process

including clear conflict of interest guidelines for all planning participants
d) Includes a method for the individual to request updates to the plan
e) Records the alternative home and community based settings that were considered for the individual
f) Includes the goals related to community living
g) Includes risk factors and the measures in place to minimize them including individualized back up plans\

(d)The plan is signed by all individuals and providers responsible for its implementation
(e) The participant and others involved in the plan are provided a copy of the plan.

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

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

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

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

For habilitation participants who are not enrolled in the Iowa Plan for Behavioral Care, the habilitation case manager initiates a request for services through this system, and Iowa Medicaid Enterprise (IME) staff responds to the request for Habilitation. Case managers complete the assessment of the need for services and submit it to the IME Medical Services unit for evaluation of program eligibility. The case manager is also responsible for entering service plan information such as the services to be received, the effective dates, the amount of each service, and the selected provider into ISIS, where it is reviewed for authorization by IME Medical Services staff.

For habilitation participants who are enrolled in the Iowa Plan for Behavioral Care, the Iowa Plan for Behavioral Health contractor has established a process for reviewing treatment plans and authorizing units of services. Contractor staff communicates by phone with the case manager or Integrated Health Home Coordinator to discuss the member's assessment and needs for service. A determination is made by the contractor for the appropriate services and units based on the assessment, treatment plan and other services the member may be receiving.

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

☐	Medicaid agency	☐	Operating agency	☑	Case manager
☑	Other *(specify):*	Integrated Health Home Care Coordinator for participants who are enrolled in an Integrated Health Home			

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	HCBS Case Management
Service Definition (Scope):	
Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Individuals who receive Targeted Case Management under the Medicaid State plan cannot also receive case management under Section 1915(i). Participants are free to choose their provider from any enrolled provider of this service	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Participants have a need for support and assistance in accessing services.	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

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

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

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Case Management Provider	Iowa Department of Human Services, Iowa Medicaid Enterprise	Verified at initial certification and thereafter based on the length of the certification (either 270 days, 1 year, or 3 years)

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title from the options for HCBS State plan services in Attachment 4.19-B)*:	

Service Title:	**Habilitation**

Service Definition (Scope):

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

Components of this service include the following:

1. Home-based Habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community.

These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Home-based habilitation also includes personal care and protective oversight and supervision. Home-based habilitation is not covered for participants residing in a residential care facility of more than 16 persons.

2. Day Habilitation means Provision of regularly scheduled activities in a non-residential setting, separate from the participant's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living.
Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the participant's person-centered plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).
Day habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's person-centered services and supports plan, such as physical, occupational, or speech therapy.

Day habilitation may be furnished in any of a variety of settings in the community other than the person's private residence. Day habilitation services are not limited to fixed-site facilities.

When transportation is provided between the participants' place of residence and the Day Habilitation service site(s) is provided as a component part of this service the cost of transportation is included in the rate paid to providers of day habilitation services,

3. Prevocational Habilitation Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process.
Individuals receiving prevocational services must have employment-related goals in their person-centered services and supports plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the optimal outcome of prevocational services.
Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills; Examples include, but are not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.
Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services provided under the waiver. Many individuals, particularly those.

Prevocational Habilitation may be furnished in any of a variety of settings in the community other than the person's private residence, the provider administrative offices or other settings that have the effect of isolating the member form the greater community.

When transportation is provided between the participants' place of residence and the Prevocational Habilitation service site(s) is provided as a component part of this service the cost of transportation is included in the rate paid to providers of prevocational habilitation services.

Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services provided under the waiver. Many individuals, particularly those transitioning from school to adult activities, are likely to choose to go directly into supported employment. Similarly, the evidence-based Individual Placement and Support (IPS) model of supported employment for individuals with behavioral health conditions emphasizes rapid job placement in lieu of prevocational services.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

4. Supported Employment Habilitation

Supported Employment -Individual Employment Support services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Supported employment services can be provided through many different service models. Some of these models can include evidence-based supported employment for individuals with mental illness, or customized employment for individuals with significant disabilities. States may define other models of individualized supported employment that promote community inclusion and integrated employment.

Supported employment individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, asset development and career advancement services, and other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting. Supported employment individual employment supports is not intended for people working in mobile work crews of small groups of people with disabilities in the community. That type of work support is addressed in the core service definition for Supported Employment Small Group employment support.

Transportation between the participant's place of residence and the employment site is a component part of supported employment individual employment supports and small group support services and the cost of this transportation is included in the rate paid to providers of supported employment individual employment supports services.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or

2. Payments that are passed through to users of supported employment services.

Supported Employment Small Group employment support (Enclave) are services and training activities provided in regular business, industry and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Supported employment small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small group employment support does not include vocational services provided in facility based work settings.
Supported employment small group employment supports may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits support, training and planning transportation and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

Transportation between the participant's place of residence and the employment site is a component part of supported employment individual employment supports and small group support services and the cost of this transportation is included in the rate paid to providers of supported employment individual employment supports services.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or

2. Payments that are passed through to users of supported employment services.

Supported Employment Habilitation may be furnished in any of a variety of settings in the community other than the person’s private residence with the exception of individual employment supports provided to an individual who is self-employed or who has an employment situation where working from the home or a home office is typical for such a position.

Additional needs-based criteria for receiving the service, if applicable (specify):	
Participants have a need for supports to assist in the acquisition, retention, or improvement in skills related to living in the community. Additionally, for the prevocational habilitation and supported employment habilitation components, individuals have a need for ongoing supports to prepare for, obtain, or maintain employment.	
Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):	
☑	Categorically needy *(specify limits):* A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2). The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours). A unit of prevocational habilitation is an hour (for up to 4 units per day) or a full day (4.25 to 8 hours). A unit of supported employment habilitation for activities to obtain a job is: 1. One job placement for job development and employer development. 2. A 15-minute unit for enhanced job search. A unit of supported employment habilitation supports to maintain employment is a 15-minute unit, maximum of 40 units per week. All limits are subject to change each year. All components of habilitation being utilized must be authorized in the participant's service plan or treatment plan. The case manager will monitor the service plan. The Integrated Health Home Care Coordinator will monitor the treatment plan
☑	Medically needy *(specify limits):* A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2). The daily unit of service shall be used when a member receives services for 8 or

	more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours). A unit of prevocational habilitation is an hour (for up to 4 units per day) or a full day (4.25 to 8 hours). A unit of supported employment habilitation for activities to obtain a job is: 1. One job placement for job development and employer development. 2. A 15-minute unit for enhanced job search. A unit of supported employment habilitation supports to maintain employment is a 15-minute unit, maximum of 40 units per week. All limits are subject to change each year. All components of habilitation being utilized must be authorized in the participant's service plan or treatment plan. The case manager will monitor the service plan. The Integrated Health Home Care Coordinator will monitor the treatment plan.

Specify whether the service may be provided by a *(check each that applies):*	☐	Relative
	☐	Legal Guardian
	☐	Legally Responsible Person

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify):*	Other Standard *(Specify):*
Home-based habilitation providers		Meet any of the following: o Accredited through the Commission on Accreditation of Rehabilitation Facilities (CARF) o Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) o Accredited by the Council on Accreditation (COA) o Accredited by the Council on Quality and Leadership (CQL) o Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Supported Community Living for the HCBS MR Waiver under 441-IAC 77.37(1) through 77.37(14) or the HCBS BI Waiver under 441-IAC 77.39(1) through 77.39(10) and 77.39(13). o Certified by the department as a provider of Supported Community Living under 441-IAC 24.2 through 24.4(8) and 24.4(12).	
Day habilitation providers		Meet any of the following: o Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) o Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) o Accredited by the Council on Quality and Leadership (CQL) o Accredited by the International Center for Clubhouse Development (ICCD) o Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider	

		of Day Habilitation for the HCBS MR Waiver under 441 IAC 77.37(13) and 77.37(27). o 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 24.4(12).	
Prevocational habilitation providers		Meet any of the following: o Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) o Accredited by the Council on Quality and Leadership (CQL) o Accredited by the International Center for Clubhouse Development (ICCD) o Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Prevocational services for the HCBS MR Waiver under 441 IAC 77.37(13) and 77.37(26) or the HCBS BI Waiver under 441-IAC 77.39(22).	
Supported employment habilitation providers		Meet any of the following: o Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) o Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) o Accredited by the Council on Accreditation (COA) o Accredited by the Council on Quality and Leadership (CQL) o Accredited by the International Center for Clubhouse Development (ICCD) o Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Supported Employment for the HCBS MR Waiver under 441 IAC 77.37(1) through 77.37(13) and 77.37(16) or the HCBS BI Waiver under 441-IAC 77.39(1) through 77.39 (10) and 77.39(15).	

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 Human Services, Iowa Medicaid Enterprise Iowa Plan for Behavioral Health contractor	Verified at initial certification and thereafter based on the length of the certification: o either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR or BI Waivers or certified under IAC 441-24 o either 1 year or 3 years when accredited by CARF; either 3 years or 4 years when accredited by COA; o 3 years when accredited by JCAHO o 4 years when accredited by CQL Verified at initial certification and thereafter based on the length of the certification:
Day habilitation providers	Iowa Department of Human Services, Iowa Medicaid Enterprise\ Iowa Plan for Behavioral Health contractor	Verified at initial certification and thereafter based on the length of the certification: o either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR Waiver or certified under IAC 441-24 o either 1 year or 3 years when accredited by CARF or ICCD o 3 years when accredited by JCAHO o 4 years when accredited by CQL Verified at initial certification and thereafter based on the length of the certification:
Prevocational habilitation providers	Iowa Department of Human Services, Iowa Medicaid Enterprise	Verified at initial certification and thereafter based on the length of the certification: o either 270 days, 1 year, or 3 years

	Iowa Plan for Behavioral Health contractor	when certified by the IME as a provider for HCBS MR or BI Waivers o either 1 year or 3 years when accredited by CARF or ICCD o 4 years when accredited by CQL Verified at initial certification and thereafter based on the length of the certification:
Supported employment habilitation providers	Iowa Department of Human Services, Iowa Medicaid Enterprise	Verified at initial certification and thereafter based on the length of the certification: o either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR or BI Waivers o either 1 year or 3 years when accredited by CARF or ICCD o either 3 years or 4 years when accredited by COA o 3 years when accredited by JCAHO o 4 years when accredited by CQL
	Iowa Plan for Behavioral Health contractor	Verified at initial certification and thereafter based on the length of the certification:

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

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

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

Participant-Direction of Services

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

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

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

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

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

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

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

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

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

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

6. ☐ **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, which recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.**6. Voluntary and Involuntary Termination of Participant-Direction.** ***(****Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). (*Select one):*

⊙	The State does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). (*Select one):*

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

Quality Improvement Strategy

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

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	1. The number and percentage of service plans which address the member's assessed health risks	1. All service plans are reviewed at least every 12 months, and may be reviewed at a greater frequency based on the member's identified needs.	1. The Iowa Plan for Behavioral Health contractor	1. Every 12 months, or more often based on the member's identified needs.	1. The Iowa Plan for Behavioral Health contractor ensures that Case Manger or Integrated Health Home Care Coordinator has addressed the member's health and safety risks during service authorization.	1. Quarterly
		2. Continuous; random sample at a 95% confidence	2. IME Medical Services QA Service Plan Desk Review	2. Continuous; random sample at a 95% confidence level.	2.The IME Medical Service 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 IME,	2. Quarterly

		level.			Medical Services Unit will send the review results to the Iowa Plan for Behavioral Health contractor and the Case Manager or Integrated Health Home Care Coordinator within 2 business days of completing the review. The Iowa Plan for Behavioral Health Contractor will address any deficiencies with the provider, Case Manager or Integrated Health Home and target training and technical assistance to those deficiencies.	
	2. Number and percent of service plans which address the member's safety risks	1. All service plans/ are reviewed at least every 12 months, and may be reviewed at a greater frequency based on the member's identified needs.	1. The Iowa Plan for Behavioral Health contractor	1. All plans are reviewed at least every 12 months, and may be reviewed at a greater frequency based on the member's identified needs.	1. The Iowa Plan for Behavioral Health contractor ensures that Case Manger or Integrated Health Home Care Coordinator has addressed the member's health and safety risks during service authorization.	1. Quarterly
		2. Continuous; random sample at a 95%	2. IME, Medical Services contractor	2. Continuous; random sample at a 95% confidence level.	2.The IME Medical Service 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	2. Quarterly

		confidence level.			or IHH Care Coordinator. The IME, Medical Services Unit will send the review results to the Iowa Plan for Behavioral Health contractor and the Case Manager or Integrated Health Home Care Coordinator within 2 business days of completing the review. The Iowa Plan for Behavioral Health Contractor will address any deficiencies with the provider, Case Manager or Integrated Health Home and target training and technical assistance to those deficiencies.	
	3. Number and percent of service plans which reflect the member's assessed personal; goals	1. All service plans are reviewed at least every 12 months, and may be reviewed at a greater frequency based on the member's identified needs. 2. Continuous; random sample at a 95%	1. The Iowa Plan for Behavioral Health contractor 2. IME Medical Services contractor	1. All plans are reviewed at least every 12 months, and may be reviewed at a greater frequency based on the member's identified needs. 2. Continuous; random sample at a 95% confidence level.	1. The Iowa Plan for Behavioral Health contractor ensures that Case Manager or Integrated Health Home Care Coordinator has addressed the member's personal goals in the service plan during service authorization. 2.The IME Medical Service 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	1. Quarterly 2. Quarterly

		confidence level. 3. Member interview – Iowa Personal Experience Survey (IPES)	3. IME , HCBS Provider Quality Oversight contractor	3. Continuous; random sample at a 95% confidence level.	or IHH Care Coordinator. The IME, Medical Services Unit will send the review results to the Iowa Plan for Behavioral Health contractor and the Case Manager or Integrated Health Home Care Coordinator within 2 business days of completing the review. The Iowa Plan for Behavioral Health Contractor will address any deficiencies with the provider, Case Manager or Integrated Health Home and target training and technical assistance to those deficiencies. 3. IME , HCBS Provider Quality Oversight contractor will send the IPES survey results to the Iowa Plan for Behavioral Health Contractor The Iowa Plan for Behavioral Health Contractor will address any deficiencies with the member, provider, Case Manager or Integrated Health Home Care Coordinator and target training and technical assistance to those deficiencies.	3. Quarterly

	4. The number and percent of service plans which are revised on or before the program member's annual due date	1. All service plan s are reviewed initially, annually and more often as the members needs require	1. The Iowa Plan for Behavioral Health contractor	1. All plans are reviewed at least every 12 months, and may be reviewed at a greater frequency based on the member's identified needs.	1. The Iowa Plan for Behavioral Health contractor ensures that Case Manager or Integrated Health Home Care Coordinator has revised the service plan on or before the member's annual due date during service authorization.	1. Quarterly
		2. Continuous; random sample at a 95% confidence level.	2. IME Medical Services contractor	2. Continuous; random sample at a 95% confidence level.	2.The IME Medical Service 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 IME, Medical Services Unit will send the review results to the Iowa Plan for Behavioral Health contractor and the Case Manager or Integrated Health Home Care Coordinator within 2 business days of completing the review. The Iowa Plan for Behavioral Health Contractor will address any deficiencies with the provider, Case Manager or Integrated Health Home and target training and technical assistance to those deficiencies.	2. Quarterly

		3. Member interview – Iowa Personal Experience Survey (IPES)	3. IME , HCBS Provider Quality Oversight	3. Continuous; random sample at a 95% confidence level.	3. IME , HCBS Provider Quality Oversightcontractor will send the IPES survey results to the Iowa Plan for Behavioral Health Contractor The Iowa Plan for Behavioral Health Contractor will address any deficiencies with the member's provider, Case Manager or Integrated Health Home Care Coordinator and target training and technical assistance to those deficiencies.	3. Quarterly
	5. Number and percent of service plans which indicates that the member was afforded a choice of service providers.	1. All service plan s are reviewed initially, annually and more often as the members needs require 2. Continuous; random sample at a 95% confidence level.	1. All service plan s are reviewed initially, annually and more often as the members needs require 2. Continuous; random sample at a 95% confidence	1. All service plan s are reviewed initially, annually and more often as the members needs require 2. Continuous; random sample at a 95% confidence.	1. The Iowa Plan for Behavioral Health contractor ensures that Case Manager or Integrated Health Home Care Coordinator has addressed the member's choice of service providers in the service plan during service authorization. 2.The IME Medical Service 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 IME, Medical Services Unit will send the review results to the Iowa Plan for Behavioral Health contractor and the Case Manager or Integrated Health Home Care Coordinator within 2 business days of completing the review.	1. Quarterly 2. Quarterly

	5. Number and percent of service plans which Indicate that the member has a backup plan	1. All service plan s are reviewed initially, annually and more often as the members needs require 2.Continuous ; random sample at a 95% confidence	1. All service plan s are reviewed initially, annually and more often as the members needs require 2. Continuous; random sample at a 95% confidence	1. All service plan s are reviewed initially, annually and more often as the members needs require 2. Continuous; random sample at a 95% confidence	1. The Iowa Plan for Behavioral Health contractor ensures that Case Manager or Integrated Health Home Care Coordinator has addressed the member's choice of service providers in the service plan during service authorization. 2.The IME Medical Service 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 IME, Medical Services Unit will send the review results to the Iowa Plan for Behavioral Health contractor and the	1. Quarterly 2. Quarterly

Members receiving state plan HCBS will reside in settings that meet the HCBS setting requirements	1. Number and percent of service plans which indicate that the member resides in a setting that meets the HCB setting requirements	1. All service plans are reviewed initially, annually and more often as the members needs require 2. Continuous; random sample at a 95% confidence level.	1. The Iowa Plan for Behavioral Health contractor 2. IME , Medical Services contractor	1. All plans are reviewed at least every 12 months, and may be reviewed at a greater frequency based on the member's identified needs. 2. Continuous; random sample at a 95% confidence level.	1. The Iowa Plan for Behavioral Health contractor ensures that Case Manager or Integrated Health Home Care Coordinator has addressed the member's setting for receipt of HCB services during service authorization. 2.The IME Medical Service 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 IME, Medical Services Unit will send the review results to the Iowa Plan for Behavioral Health contractor and the Case Manager or Integrated Health Home Care Coordinator within 2 business days of completing the review.	1. Quarterly 2. Quarterly
Providers Meet Qualifications	1. Number and percent of program provider enrollment applications verified against appropriate licensing and or certification entity.	1. 100% of provider enrollment applications are reviewed upon enrollment.	1. The Iowa Plan for Behavioral Health contractor	1. Initially at the time of enrollment and every 3 years thereafter	1. The Iowa Plan for Behavioral Health contractor manages the provider network and does not enroll providers who cannot meet the required qualifications. Providers must be reenrolled in the Iowa Plan for Behavioral Health Provider Network every 3 years	1. Quarterly

	2. Number and percent of program provider enrollment applications who indicate that abuse and criminal background checks were completed	1. 100% of provider enrollment applications are reviewed upon enrollment.	1. The Iowa Plan for Behavioral Health contractor	1. Initially at the time of enrollment and every 3 years thereafter	1 The Iowa Plan for Behavioral Health contractor manages the provider network and does not enroll providers who cannot meet the required qualifications. Providers must be reenrolled in the Iowa Plan for Behavioral Health Provider Network every 3 years	1. Quarterly
	3. Number and percent of currently enrolled providers verified against the appropriate licensing or certification entity.	1. 100% of provider enrollment applications are reviewed upon enrollment.	1. The Iowa Plan for Behavioral Health contractor	1. Initially at the time of enrollment and every 3 years thereafter	1 The Iowa Plan for Behavioral Health contractor manages the provider network and does not enroll providers who cannot meet the required qualifications. Providers must be reenrolled in the Iowa Plan for Behavioral Health Provider Network every 3 years	1. Quarterly

	4. Number and percent of currently enrolled providers who indicate that abuse and criminal background checks were completed	1. 100% of provider enrollment applications are reviewed upon enrollment.	1. The Iowa Plan for Behavioral Health contractor	1. Initially at the time of enrollment and every 3 years thereafter	1 The Iowa Plan for Behavioral Health contractor manages the provider network and does not enroll providers who cannot meet the required qualifications. Providers must be reenrolled in the Iowa Plan for Behavioral Health Provider Network every 3 years	1. Quarterly
	5. Number and percent of providers that meet training requirement as outlined in state regulations	1. 100% of provider enrollment applications are reviewed upon enrollment.	1. The Iowa Plan for Behavioral Health contractor	1. Initially at the time of enrollment and every 3 years thereafter	1 The Iowa Plan for Behavioral Health contractor manages the provider network and does not enroll providers who cannot meet the required qualifications. Providers must be reenrolled in the Iowa Plan for Behavioral Health Provider Network every 3 years	1. Quarterly

The SMA retains authority and responsibility for program operations and oversight.	1. Number and percent of quarterly contract management reports, from the Iowa Plan for Behavioral Health Contractor submitted within ten business days of the end of the reporting period.	1. 100%	1. IME Contracted entity performance monitoring	1. Monthly , ongoing	1. IME, Iowa Plan for Behavioral Health Contract Manager	1. Quarterly
	2. Number and percent of quarterly contract management reports, from the HCBS QA Contractor, submitted within ten business days of the end of the reporting period	1. 100%	1. IME Contracted entity performance monitoring	1. Monthly , ongoing	1. IME, HCBS Quality Assurance Manager	1. Quarterly

	4. Number and percent of monthly major incident reports, received from the Iowa Plan for Behavioral Health Contractor within ten business days of the end of the reporting period.	1. 100%	1. IME Contracted entity performance monitoring	1. Monthly , ongoing	1. The Iowa Plan for Behavioral Health contractor will send the incident report data to the IME, HCBS Quality Assurance Manager. The IME HCBS Quality Assurance Committee will review the data quarterly and address any trends requiring additional follow up with the Iowa Plan for Behavioral Health Contractor.	1. Quarterly
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	1. The number and percent of paid claims for which the units of service lacked supporting documentation	1. 100% 2. Annual Billing Review of Magellan Program Integrity	1. The Iowa Plan for Behavioral Health Contractor 2. IME, Program Integrity	1. Continuous and ongoing 2. Annually	1. The Iowa Plan for Behavioral Health contractor 2. IME, Program Integrity Director	1. Quarterly 2. Quarterly

The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1. Number and percent and frequency of major incidents by type	1. 100%, major incident reports	1. The Iowa Plan for Behavioral Health Contractor	1. Monthly	1. The Iowa Plan for Behavioral Health Contractor initiates 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 Iowa Plan for Behavioral Health staff becomes aware of an adverse incident the incident is communicated to the Unit Medical Director and the Quality and Compliance Director. If deemed high risk the Compliance Director request records from the service providers and the incident is communicated to clinical leadership within 24 hours. Within 5 business days the Legal Dept. reviews the case to determine if an incident review is required. A full audit of the incident is completed within 15 days The Iowa Plan for Behavioral Health contractor will send the incident report data to the IME, HCBS Quality Assurance Manager. The IME HCBS Quality Assurance Committee will review the data quarterly and address any trends requiring additional follow up with the Iowa Plan for Behavioral Health Contractor.	1. Quarterly

	2. Number and percent of major incidents that were reported within the required timeframes specified in the program	1. 100% major incident reports	1. The Iowa Plan for Behavioral Health Contractor	1. Monthly	The Iowa Plan for Behavioral Health Contractor initiates 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 Iowa Plan for Behavioral Health staff becomes aware of an adverse incident the incident communicated to the Unit Medical Director and the Quality and Compliance Director. If deemed high risk the Compliance Director request records from the service providers and the incident is communicated to clinical leadership within 24 hours. Within 5 business days the Legal Dept. reviews the case to determine if an incident review is required. A full audit of the incident is completed within 15 days The Iowa Plan for Behavioral Health contractor will send the incident report data to the IME, HCBS Quality Assurance Manager. The IME HCBS Quality Assurance Committee will review the data quarterly and address any trends requiring additional follow up with the Iowa Plan for Behavioral Health Contractor.	1. Quarterly

	3. Number and percent of incidents related to dangerous behavior of the member	1. 100% critical incident reports	1. The Iowa Plan for Behavioral Health Contractor	1. Monthly	The Iowa Plan for Behavioral Health Contractor initiates 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 Iowa Plan for Behavioral Health staff becomes aware of an adverse incident the incident communicated to the Unit Medical Director and the Quality and Compliance Director. If deemed high risk the Compliance Director request records from the service providers and the incident is communicated to clinical leadership within 24 hours. Within 5 business days the Legal Dept. reviews the case to determine if an incident review is required. A full audit of the incident is completed within 15 days The Iowa Plan for Behavioral Health contractor will send the incident report data to the IME, HCBS Quality Assurance Manager. The IME HCBS Quality Assurance Committee will review the data quarterly and address any trends requiring additional follow up with the Iowa Plan for Behavioral Health Contractor.	1. Quarterly

	4. Number and percentage of unexplained, suspicious or untimely deaths compared to total deaths	1. 100% critical incident reports	1. The Iowa Plan for Behavioral Health Contractor	1. Monthly	The Iowa Plan for Behavioral Health Contractor initiates 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 Iowa Plan for Behavioral Health staff becomes aware of an adverse incident the incident communicated to the Unit Medical Director and the Quality and Compliance Director. If deemed high risk the Compliance Director request records from the service providers and the incident is communicated to clinical leadership within 24 hours. Within 5 business days the Legal Dept. reviews the case to determine if an incident review is required. A full audit of the incident is completed within 15 days The Iowa Plan for Behavioral Health contractor will send the incident report data to the IME, HCBS Quality Assurance Manager. The IME HCBS Quality Assurance Committee will review the data quarterly and address any trends requiring additional follow up with the Iowa Plan for Behavioral Health Contractor.	1. Quarterly

	5. The number and percent of service plans that indicate the members were informed of how to report suspected abuse, neglect or exploitation.	1. All service plan s are reviewed initially, annually and more often as the members needs require 2. Continuous ; random sample at a 95% confidence level.	1. The Iowa Plan for Behavioral Health contractor 2. IME Medical Services QA Service Plan Desk Review	1. Every 12 months, or more often based on the member's identified needs. 2. Continuous; random sample at a 95% confidence level	1. The Iowa Plan for Behavioral Health contractor ensures that Case Manger or Integrated Health Home Care Coordinator has addressed the member's health and safety risks during service authorization. 2.The IME Medical Service 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 IME, Medical Services Unit will send the review results to the Iowa Plan for Behavioral Health contractor and the Case Manager or Integrated Health Home Care Coordinator within 2 business days of completing the review. The Iowa Plan for Behavioral Health Contractor will address any deficiencies with the provider, Case Manager or Integrated Health Home and target training and technical assistance to those deficiencies.	

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 QA/QI system, at a minimum, addresses: • Health and safety issues of members receiving HCBS services • Abuse/neglect/exploitation of members • Member access to services • Plan of Care discrepancies • Availability of services • Complaints of service delivery • Training of providers, case managers, and other stakeholders • Emergency procedures • Provider qualifications • Member choice	Data shall come from a variety of sources including the Iowa Plan for Behavioral Health contractor, HCBS Provider Quality Oversight databases, site reviews, follow-up compliance reviews, complaint investigations, evaluation reports, member satisfaction surveys, member interviews, and member records.	The QA/QI system shall continuously collect data for use in improving quality of services	Data from all QA/QI activities is compiled by the HCBS Provider Quality Oversight Specialists and presented to the HCBS QA/QI committee on a quarterly basis. The QA/QI committee analyzes the data to determine patterns, trends, problems, and issues in service delivery of HCBS services. Based on this analysis, recommendations for changes in policy are made to the IME 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 QA/QI committee is made up of certain HCBS Provider Quality Oversight staff and supervisors (who function under the Telligen contract), and IME 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 improvement are made
The Department performs an annual review of each managed care plan. This is generally conducted at the time of the annual External Quality Review (EQR) and	IME Contract Manager	Annual	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 during on site visits and through regular reports. The Medical Services Unit conducts an annual EQR of each managed care entity to ensure that they are following the

will include a determination of contract compliance, including that for fraud and abuse reporting and training.			outlined QA/QI plan.
EQR is performed as federally required. 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 during on site visits and through regular reports.	External Quality Review Organization (EQRO) Contractor – Telligen	EQR is performed as federally required. Committee reports are reviewed during an annual visit.	The Medical Services Unit contractor Telligen is the contracted EQRO that conducts an annual EQR of each managed care entity to ensure that they are following the outlined QA/QI plan. 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 during on site visits and through regular reports.
The Iowa Plan for Behavioral Health has earned National Committee for Quality Assurance (NCQA) Accreditation for a Managed Behavioral Health Organization (MBHO) by proving their proficiency across five standards: **MBHO 1. Quality Management and Improvement The** organization has processes designed to monitor, evaluate and improve the quality and safety of care provided to its	The Iowa Plan for Behavioral Health Contractor	NCQA Accreditation review occurs every three years	NCQA does publically 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 a number of standards and measures through an accreditation star rating comprised of five categories (access and service, qualified providers, staying healthy, getting better, living with illness).

members, including those with complex needs. **MBHO 2. Care Coordination** The organization coordinates medical care and behavioral healthcare for its members? **MBHO 3. Utilization Management** The organization notifies members and practitioners about coverage decisions within required time frames. **MBHO 4. Credentialing and Recredentialing** The organization verifies the credentials of the practitioners in its network. **MBHO 5. Members' Rights and Responsibilities** The organization has a written members' rights and responsibilities policy.			

☑	Habilitation	
	HCBS Case Management	
	Providers of case management services shall be reimbursed at cost. Providers are reimbursed throughout each fiscal year on the basis of a projected interim payment rate for a 15-minute unit of service based on each provider's reasonable and proper costs of operation. Reasonable and proper costs of operation are identified pursuant to federally accepted reimbursement principles (OMB A-87 principles). The methodology for determining the reasonable and proper cost for service provision assumes the following: • The indirect administrative costs shall be limited to 23 percent of other costs. Other costs include: professional staff – direct salaries, other – direct salaries, benefits and payroll taxes associated with direct salaries, mileage and automobile rental, agency vehicle expense, automobile insurance, and other related transportation. • Mileage shall be reimbursed at a rate no greater than the state employee rate. • Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A). Interim payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664., Financial and Statistical Report submitted by providers ninety days aftere each fiscal year end. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost apportionment.	
☑	HCBS Home-Based Habilitation	
	For services provided on July 1, 2013 through December 31, 2013, home-based 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 January 1, 2014, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html	

	☑	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 January 1, 2014, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html
	☐	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 January 1, 2014, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html
	☑	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 home-based habilitation. The agency's fee schedule rate was set as of January 1, 2014, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html

☐

	Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

2. **Presumptive Eligibility for Assessment and Initial HCBS.** Period of presumptive payment for HCBS assessment and initial services, as defined by 1915(i)(1)(J) *(Select one):*

◉	The State does not elect to provide for a period of presumptive payment for individuals that the State has reason to believe may be eligible for HCBS.
○	The State elects to provide for a period of presumptive payment for independent evaluation, assessment, and initial HCBS. Presumptive payment is available only for individuals covered by Medicaid that the State has reason to believe may be eligible for HCBS, and only during the period while eligibility for HCBS is being determined. The presumptive period will be [ ] days (not to exceed 60 days).