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

TARGETED CASE MANAGEMENT SERVICES
Target Group 1

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
Adults with chronic mental illness (CMI), and severely emotionally disturbed (SED) children receiving services through the HCBS Children's Mental Health waiver.

Persons eligible for targeted case management services in this target group are adults (age 18 or older) that have a diagnosis of chronic mental illness, and children (age 17 or under) eligible for the HCBS Children's Mental Health waiver. They have functional limitations and lack the ability to independently access and sustain involvement in necessary services.

Chronic mental illness means the condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment.

Persons with chronic mental illness typically meet at least one of the following criteria:

1. They have undergone 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).
2. They have experienced at least one episode of continuous, structured supportive residential care other than hospitalization.

In addition, people with chronic mental illness typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

1. They are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
2. They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
3. They show severe inability to establish or maintain a personal social support system.
4. They require help in basic living skills.
5. They exhibit inappropriate social behavior that results in demand for intervention by the mental health or judicial system.

In atypical instances, a person who varies from these criteria could still be considered to be a person with chronic mental illness. Persons with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

Serious Emotional Disturbance means a diagnosable mental, behavioral, or emotional disorder that:

1. Is of sufficient duration to meet diagnostic criteria for the disorder specified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), published by the American Psychiatric Association; and
2. Has resulted in a functional impairment that substantially interferes with or limits the person's role or functioning in family, school, or community activities.

Serious emotional disturbance does not include developmental disorders, substance-related disorders, or conditions or problems classified in DSM-IV-TR as "other conditions that may be a focus of clinical attention" (V codes), unless these conditions co-occur with another diagnosable serious emotional disturbance.

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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):
X Entire State
___ Only in the following geographic areas:

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;
  - 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

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- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

❖ Monitoring and follow-up activities:
- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. Case management contacts shall occur as frequently as necessary, but shall consist of no less than one contact per month and must include at least one face-to-face contact with the individual every three months. Contact may be face-to-face, by telephone, or by written communication.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Case management services will be provided by the Iowa Department of Human Services, by a county, or by a consortium of counties. Providers may subcontract for the provision of case management services. All providers, including subcontractors, must be accredited under Iowa Administrative Code 441- Chapter 24, which includes the following qualifications for individuals providing case management:

- 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 services to the population groups that the person is hired to serve; or
- An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired to serve.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

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TARGETED CASE MANAGEMENT SERVICES
Target Group 1

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

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TARGETED CASE MANAGEMENT SERVICES
Target Group 1

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES
Target Group 2

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
Persons with a developmental disability, including mental retardation.

Persons eligible for targeted case management services in this target group have a primary diagnosis of mental retardation or developmental disability. They have functional limitations and lack the ability to independently access and sustain involvement in necessary services. This target group does not include persons residing in an ICF-MR.

Developmental Disability means a severe, chronic disability that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the age of 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and
5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

Mental Retardation means a diagnosis of mental retardation which:

1. Is made only when the onset of the person's condition was before the age of 18 years;
2. Is based on an assessment of the person's intellectual functioning and level of adaptive skills;
3. Is made by a psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills; and
4. Is made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

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):

X Entire State
___ Only in the following geographic areas:

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

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Target Group 2

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;
  - 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
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. Case management contacts shall occur as frequently as necessary, but shall consist of no less than one contact per month and must include at least one face-to-face contact with the individual every three months. Contact may be face-to-face, by telephone, or by written communication.

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TARGETED CASE MANAGEMENT SERVICES
Target Group 2

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Case management services will be provided by the Iowa Department of Human Services, by a county, or by a consortium of counties. Providers may subcontract for the provision of case management services. All providers, including subcontractors, must be accredited under Iowa Administrative Code 441- Chapter 24, which includes the following qualifications for individuals providing case management:

- 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 services to the population groups that the person is hired to serve; or
- An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired to serve.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

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Target Group 2

- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

All other payments for the services of an nurse-midwife enrolled in the Iowa Medicaid program shall be paid on the basis of the fee schedule for services provided nurse mid-wives and no separate payment shall be made to any other facility or provider in connection with the birth, other than a hospital, or ambulatory surgical center. The nurse-midwife fee schedule is based on 85% of the physician fee schedule.

18. HOSPICE SERVICES

Iowa Medicaid reimburses for hospice services in accordance with the requirements of Section 4306 of the State Medicaid Manual (Hospice Reimbursement).

Pursuant to Section 4307 of the State Medicaid Manual (Payment for Physician Services Under Hospice), when the Iowa Medicaid agency has been notified of the name of the physician who has been designated as the attending physician and is not a hospice employee, the Iowa Medicaid Agency will reimburse the attending physician in accordance with the physician fee schedule described in Item 5a.

19a. CASE MANAGEMENT SERVICES

For target group 1 (Adults with chronic mental illness, and severely emotionally disturbed children receiving services through the HCBS Children's Mental Health waiver); and target group 2 (Persons with a developmental disability, including mental retardation):

For the period of December 3, 2009, through June 30, 2010, case management services, as described in Supplement 2 to Attachment 3.1-A, will be reimbursed using a monthly unit established on the basis of the provider's reasonable and necessary costs in accordance with the Office of Management and Budget Circular A-87, "Cost Principles for State and Local Governments." A prospective cost-based interim rate will be set based on the finalized FYE June 30, 2009 financial and statistical cost report. An inflation factor of 4.8% will be applied from midpoint of the cost report period to midpoint of the rate period (January 1, 2009 through March 15, 2010), then reduced by 2.5% resulting in an inflation factor of 2.3%. If the provider's cost does not support the payments made during December 1, 2009, – June 30, 2010, the provider will be required to return the difference between actual cost and the prospective cost-based rate. If actual cost exceeds the prospective cost-based rate the amount paid to the provider shall be actual cost less 2.5% not to go lower than the prospective cost-based rate. Because case management is the only service provided by case management providers, enrolled providers are not required to complete CMS approved time studies. The indirect cost rate for each provider is reviewed and monitored annually by the State Medicaid Agency.

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For the period July 1, 2010, and thereafter, reimbursement rates for case management providers will be established on the basis of a 15 minutes unit in accordance with the Office of Management and Budget Circular A-87, "Cost Principles for State and Local Governments." Case Management services, as described in Supplement 2 to Attachment 3.1-A, will be reimbursed on the basis of 100% of the provider's reasonable and necessary costs calculated retrospectively, as determined by the State Medicaid agency.

Interim Payment

The Department will make interim payments to Case Management providers based upon a projected cost report. Providers are required to submit a CMS-approved, Medicaid projected cost report on July 1 of each year for the purpose of establishing a projected rate for the new fiscal year, thus avoiding underpayment or overpayment.

Annual Cost Report Process

Case Management providers are required to submit a CMS-approved, Medicaid cost report to the Department 90 days after each fiscal year end. A 30-day extension of the Medicaid cost report due date may be granted upon request by the Case Management.

The Medicaid cost report data includes direct costs, programmatic indirect costs, and general and administrative costs. Direct costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel and other direct costs related to the delivery of Case Management services. Programmatic indirect costs include salaries, benefits and other costs that are indirectly related to the delivery of Case Management services. General and administrative overhead costs include the salaries, benefits and other costs that, while not directly part of the Case Management service, constitute costs that support the operations of the Case Management agency. These general and administrative overhead costs are included in accordance with OMB Circular A-87. Case Management providers must eliminate unallowable expenses from the cost report. If they are not removed Iowa Medicaid will make the appropriate adjustments to the Case Management's Medicaid cost report.

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Cost Reconciliation Process

The cost reconciliation must be completed within twenty-four (24) months of the end of the cost report period covered by the annual Medicaid cost report. The total Medicaid allowable costs per unit are compared to the interim projected rate paid for services delivered during the reporting period. Retroactive claim adjustments are made based on the final rates determined using the final actual financial reports.

Because case management is the only service provided by case management providers, enrolled providers are not required to complete CMS approved time studies. The method of cost apportionment specified in OMB Circular A-87 shall be used to determine the actual cost of services rendered to Medicaid recipients. The indirect cost rate for each provider is reviewed and monitored annually by the State Medicaid Agency.

Target Group 3

For target group 3 (Children from birth to age three who meet the "developmental delay" eligibility categories set forth in the federal regulations under Part C of the Individuals with Disabilities Education Act (IDEA)):

Case management services are reimbursed according to a fee schedule, established September 1, 2002 and updated July 1, 2005 for services rendered on or after that date, based on 15-minute units of service. The number of 15-minute units billed cannot exceed 24 per day per case manager.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of case management for target group 3 and the fee schedule and any annual periodic adjustments to the fee schedule are published on the agency's website at: www.ime.state.ia.us/Reports_Publications/FeeSchedule.html .

19b RESERVED

20. EXTENDED SERVICES FOR PREGNANT WOMEN

Fee Schedule.

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Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☑	HCBS Case Management
	For the period July 1, 2010, and thereafter, reimbursement rates for case management providers will be established on the basis of a 15- minute unit in accordance with the Office of Management and Budget Circular A-87, "Cost Principles for State and Local Governments." Case Management services will be reimbursed on the basis of 100% of the provider's reasonable and necessary costs calculated retrospectively, as determined by the State Medicaid agency. Providers are required to submit a cost report on July 1 of each year for the purpose of establishing a projected rate for the new fiscal year, thus avoiding underpayment or overpayment. A cost report showing actual costs is submitted ninety days after each fiscal year end. An interim rate based on the State Medicaid agency's estimate of actual reasonable and necessary costs for the services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports. Because case management is the only service provided by case management providers, enrolled providers are not required to complete CMS approved time studies. The method of cost apportionment specified in OMB Circular A-87 shall be used to determine the actual cost of services rendered to Medicaid recipients. The indirect cost rate for each provider is reviewed and monitored annually by the State Medicaid Agency.
☐	HCBS Homemaker
	☐ HCBS Basic Homemaker
	☐ HCBS Chore Services
☐	HCBS Home Health Aide
☐	HCBS Personal Care
	☐ HCBS Personal Care I
	☐ HCBS Personal Care II
	☐ HCBS Attendant Services
	☐ HCBS Adult Companion
	☐ HCBS Personal Emergency Response Systems