

Table of Contents

State/Territory Name: IA

State Plan Amendment (SPA) #: 18-0014

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Summary Form (with 179-like data)
- 3) Approved SPA Pages

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

November 8, 2018

Michael Randol, Medicaid Director
Division of Medical Services
Department of Human Services
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, IA 50315

Dear Mr. Randol:

On August 30, 2018, the Centers for Medicare & Medicaid Services (CMS) received Iowa's State Plan Amendment (SPA) Transmittal #18-0014. The purpose of the SPA is to implement changes to Iowa's 1915(i) State Plan Home and Community-Based Services (HCBS) program, by updating the performance measures to align with the measures found in the state's 1915(c) HCBS waivers.

SPA #18-0014 was approved on November 5, 2018, with an effective date of October 1, 2018, as requested by the state. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages (pp. 44-62C of Attachment 3.1-C) for incorporation into the Iowa State Plan.

If you have any questions regarding this amendment, please contact Laura D'Angelo at (816) 426-5925.

Sincerely,

11/8/2018

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

Signed by: James G. Scott -A

cc:

Mikki Stier, Deputy Director, Iowa DHS
Jennifer Steenblock, IME
Alisa Horn, IME
LeAnn Moskowitz, IME
Sandra Levels, DMCHO

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER <u>1 8 — 0 1 4</u>	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 October 1, 2018	

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 Federal mandate	7. FEDERAL BUDGET IMPACT a. FFY 2018 \$ <u>0</u> b. FFY 2019 \$ <u>0</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 3.1-C, pages 44-62 Attachment 3.1-C, pages 62A - 62C (new pages)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (if Applicable) Attachment 3.1-C, pages 44-62

10. SUBJECT OF AMENDMENT

Related to the implementation of the amended HCBS performance measures approved by CMS in the 1915(c) HD Waiver.

11. GOVERNOR'S REVIEW (Check One)

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

12. SIGNATURE OF STATE AGENCY OFFICIAL	16. RETURN TO JERRY R FOXHOVEN DIRECTOR DEPARTMENT OF HUMAN SERVICES 1305 EAST WALNUT 5TH FLOOR DES MOINES IA 50319-0114
13. TYPED NAME Jerry R. Foxhoven	
14. TITLE DIRECTOR	
15. DATE SUBMITTED 8-30-18	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED August 30, 2018	18. DATE APPROVED November 5, 2018
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL October 1, 2018	20. SIGNATURE OF REGIONAL OFFICIAL
21. TYPED NAME James G. Scott	22. TITLE Associate Regional Administrator for Medicaid and Children's Health Operations

23. REMARKS

State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 44
 Supersedes: IA-17-003

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Frequency <i>(Analysis and Aggregation)</i>
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	<p>SP-1: The IME shall measure the number and percent of service plans that accurately reflect the member's assessed needs. The assessed needs must include, at a minimum, personal goals, health risks, and safety risks.</p> <p>Numerator = # of service plans that address all member assessed needs including health and safety risks, and personal goals.</p> <p>Denominator = # of reviewed service plans</p>	<p>Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state.</p> <p>The Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. MCOs are responsible for oversight of service plans for their members.</p> <p>The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. These questions are considered urgent in</p>	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is Collected Monthly	<p>The MCO ensures that the Case Manager, Community-based Case Manager or Integrated Health Home Care Coordinator has addressed the member's health and safety needs in the member's service or treatment plan.</p> <p>The Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. MCOs are responsible for oversight of service plans for their members.</p> <p>The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager.</p> <p>General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.</p>	Data is Aggregated and Analyzed Quarterly

State: Iowa

§1915(i) State plan HCBS

Attachment 3.1-C

TN: IA 18-014

Page 45

Effective: October 1, 2018

Approved: November 5, 2018

Supersedes: IA-17-003

		<p>nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager.</p> <p>General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.</p>				
	<p>SP-2: The IME will measure the number and percent of service plans which are updated on or before the member's annual due date.</p> <p>Numerator = # of service plans updated prior to due date;</p> <p>Denominator = # of service plans reviewed</p>	<p>Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state.</p> <p>See SP-1 Above</p>	<p>State Medicaid Agency & Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly</p>	<p>See SP-1 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
	<p>SP-3 The IME will measure the number and percent of service plans which were</p>	<p>Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed</p>	<p>State Medicaid Agency & Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly</p>	<p>See SP-1 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>

State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 46
 Supersedes: IA-17-003

<p>revised when warranted by a change in the member's needs.</p> <p>Numerator = # of service plans updated or revised when warranted by changes to the member's needs.</p> <p>Denominator = # of reviewed service plans</p>	<p>and reported to the state. See SP-1 Above</p>					
<p>SP-4: The IME will measure the # and percent of members' service plans that identify all the following elements; amount, duration, and funding sources of all services and all services authorized in the service plan were provided as verified by supporting documentation.</p> <p>Numerator: # members receiving services authorized in their service plan;</p> <p>Denominator = # of service plans reviewed.</p>	<p>Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state.</p> <p>See SP-1 Above</p>	<p>State Medicaid Agency & Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly</p>	<p>See SP-1 Above</p>	<p>See SP-1 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
<p>SP-5: The IME will measure the number and percentage of members from the HCBS IPES who</p>	<p>Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the</p>	<p>State Medicaid Agency & Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly</p>	<p>See SP-1 Above</p>	<p>See SP-1 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>

State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 47
 Supersedes: IA-17-003

	<p>responded that they had a choice of services</p> <p>Numerator = # of IPES respondents who stated that they were a part of planning their services;</p> <p>Denominator = # of IPES respondents that answered the question asking if they were a part of planning their services.</p>	<p>state.</p> <p>See SP-1 Above</p>				
	<p>SP-6: The IME will measure the number and percentage of service plans from the HCBS QA survey review that indicated the member had a choice of providers.</p> <p>Numerator: The total number of service plans reviewed which demonstrate choice of HCBS service providers;</p> <p>Denominator: The total number of service plans reviewed..</p>	<p>Member service plans are reviewed at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state.</p> <p>See SP-1 Above</p>	<p>State Medicaid Agency & Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly</p>	<p>See SP-1 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
<p>Providers meet required qualifications.</p>	<p>QP-1: The IME will measure the number and percent of licensed or certification waiver provider enrollment applications verified</p>	<p>Encounter data, claims data and enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly</p>	<p>Contracted Entities (Including MCOs) manage the provider networks and do not enroll providers who cannot meet the required qualifications.</p> <p>If it is discovered by Provider Services</p>	<p>Data is Aggregated and Analyzed Quarterly</p>

State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 48
 Supersedes: IA-17-003

	<p>against the appropriate licensing and/or certification entity.</p> <p>Numerator = # and percent of waiver providers verified against appropriate licensing and/or certification entity prior to providing services.</p> <p>Denominator = # of licensed or certified waiver providers.</p>	<p>the IME Provider services.</p> <p>The IME Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment. All MCO providers must be enrolled as verified by IME Provider Services.</p> <p>The Home and Community Based Services (HCBS) quality oversight unit is responsible for reviewing provider records at a 100% level over a three to five year cycle, depending on certification or accreditation. If it is discovered that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct</p>			<p>Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, the provider is required to correct deficiency prior to enrollment or reenrollment approval. Until the provider makes these corrections, they are ineligible to provide services to waiver members. All MCO providers must be enrolled as verified by IME Provider Services, so if the provider is no longer enrolled by the IME then that provider is no longer eligible to enroll with an MCO.</p> <p>If it is discovered during HCBS Quality Oversight Unit review that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated is noncompliance persists.</p> <p>General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and required changes in individual provider policy.</p>	
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State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 49
 Supersedes: IA-17-003

		noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated if noncompliance persists. .Data is inductively analyzed at a 100% level.				
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	<p>QP-2: The IME will measure the total number and percent of providers, that meet training requirements as outlined in State regulations.</p> <p>Numerator = # of reviewed HCBS providers which did not have a corrective action plan issued related to training;</p> <p>Denominator = # of HCBS waiver providers that had a certification or periodic quality assurance review</p>	<p>OnBase and MCO reports are used to retrieve data associated with the number reviewed providers who meet training requirements. Data is inductively analyzed of 100% sample spread over 5 years.</p> <p>The IME Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment. All MCO providers must be enrolled as verified by IME Provider Services.</p>	Contracted Entity (Including MCOs)	Data is Collected Continuously and Ongoing	See QP-1 Above	Data is Aggregated and Analyzed Quarterly
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State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 50
 Supersedes: IA-17-003

		<p>The Home and Community Based Services (HCBS) quality oversight unit is responsible for reviewing provider records at a 100% level over a three to five year cycle, depending on certification or accreditation. If it is discovered that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated if noncompliance persists.</p>				
<p>Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).</p>	<p>SR-1: Number and percent of service plans which indicate that the member resides in a setting that meets the HCB setting requirements. Numerator: The total number of service plans reviewed which indicate that the member resides in a setting that meets the HCB setting</p>	<p>Member service plans are reviewed annually, and more frequently as member needs require, at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state.</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Continuously and Ongoing</p>	<p>Contracted Entities (Including MCOs) ensure that Case Managers or Integrated Health Home Care Coordinators have addressed the member’s health and safety risks during service authorization. The IME Medical Services Unit completes the QA Service Plan Desk Review within 10 days of receipt of the information from the member’s HCB service provider(s) and the Case Manager or IHH Care Coordinator. The IME Medical Services Unit will send the review results to the MCO and the Case Manager or Integrated Health Home</p>	<p>Data is Aggregated and Analyzed Quarterly</p>

State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS

Approved: November 5, 2018

Attachment 3.1-C
 Page 51
 Supersedes: IA-17-003

	<p>requirements</p> <p>Denominator: The total number of service plans reviewed.</p>				<p>Coordinator within 2 business days of completing the review.</p>	
	<p>SR-2: Number and percent of service plans which indicate that the member is receiving services in a setting that meets the HCB setting requirements.</p> <p>Numerator: The total number of service plans reviewed which indicate that the member resides in a setting that meets the HCB setting requirements</p> <p>Denominator: The total number of service plans reviewed.</p>	<p>Member service plans are reviewed annually, and more frequently as member needs require, at a 95% confidence level on a three-year cycle. Data is inductively analyzed and reported to the state.</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Continuously and Ongoing</p>	<p>Contracted Entities (Including MCOs) ensure that Case Managers or Integrated Health Home Care Coordinators have addressed the member’s health and safety risks during service authorization. The IME Medical Services Unit completes the QA Service Plan Desk Review within 10 days of receipt of the information from the member’s HCB service provider(s) and the Case Manager or IHH Care Coordinator. The IME Medical Services Unit will send the review results to the MCO and the Case Manager or Integrated Health Home Coordinator within 2 business days of completing the review.</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
<p>The SMA retains authority and responsibility for program operations and oversight.</p>	<p>AA-1: The IME shall measure the number and percent of required MCO HCBS Performance Measure Quarterly reports that are submitted timely.</p> <p>Numerator: # of MCO HCBS Performance Measure Quarterly Reports submitted timely</p>	<p>Contracted Entity and MCO performance monitoring.</p> <p>Data is inductively analyzed at a 100% level. Through the Bureau of Managed Care each MCO is assigned state staff as the contract manager; and other state staff are</p>	<p>State Medicaid Agency and Contracted Entity (Including MCOs)</p>	<p>Data is reported Monthly</p>	<p>Each MCO contract manager is responsible for ensuring that the MCO submits reports timely. If the contract manager, or policy staff as a whole, discovers and documents a repeated deficiency in performance of the MCO, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of payment compensation.</p> <p>General methods for problem correction</p>	<p>Data is Aggregated and Analyzed Quarterly</p>

State: Iowa

§1915(i) State plan HCBS

Attachment 3.1-C

TN: IA 18-014

Page 52

Effective: October 1, 2018

Approved: November 5, 2018

Supersedes: IA-17-003

	<p>Denominator: # of MCO HCBS Performance Measure Quarterly reports due in a calendar quarter.</p>	<p>assigned to aggregate and analyze MCO data. This staff oversees the quality and timeliness of monthly reporting requirements. Whenever data is late or missing the issues are immediately addressed by each MCO account manager to the respective MCO.</p>			<p>include revisions to state contract terms based on lessons learned.</p>	
	<p>AA-2: The IME shall measure the number and percent of months in a calendar quarter that each MCO reported all HCBS PM data measures.</p> <p>Numerator = # of months each MCO entered all required HCBS PM data;</p> <p>Denominator = # of reportable HCBS PM months in a calendar quarter</p>	<p>Contracted Entity performance monitoring.</p> <p>Data is inductively analyzed at a 100% level.</p> <p>See AA-1 Above</p>	<p>State Medicaid Agency and Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly</p>	<p>See AA-1 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>

State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 53
 Supersedes: IA-17-003

<p>The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.</p>	<p>FA-1: The IME will determine the number and percent of FFS reviewed claims supported by provider documentation.</p> <p>Numerator = # of reviewed paid claims where documents supports the units of service;</p> <p>Denominator = # of reviewed paid claims</p>	<p>The Program Integrity (PI) unit requests service documentation from providers and cross-walks with claims. The Program Integrity Unit utilizes an algorithm that establishes providers exceeding the norm rate and unit charged. 100% of these providers are reviewed quarterly.</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Quarterly</p>	<p>When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments; require screening of all claims, referral to MFCU, or provider suspension.</p> <p>The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a quarterly basis. If during the review of capitation payments the IME determines that a capitation was made in error, that claim is adjusted to create a corrected payment.</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
	<p>FA-2: The IME will determine the number of clean claims that are paid by the managed care organizations within the timeframes specified in the contract</p> <p>Numerator = # of clean claims that are paid by the managed care organization within the timeframes specified in the contract;</p> <p>Denominator = # of</p>	<p>100% of MCO claims data is compared to the contractual obligations for MCO timeliness of clean claim payments. Data is provided to the HCBS staff as well as to the Bureau of Managed Care.</p> <p>Data sources includes; Claims Data, adjudicated claims summary, claims aging summary, and claims lag report</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Quarterly</p>	<p>See FA-1 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>

State: Iowa

§1915(i) State plan HCBS

Attachment 3.1-C

TN: IA 18-014

Page 54

Effective: October 1, 2018

Approved: November 5, 2018

Supersedes: IA-17-003

<p>Managed Care provider claims.</p>					
<p>FA-3: The IME will measure the number and percent of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for the services provided.</p> <p>Numerator = # of reviewed claims paid using IME-approved rate methodologies;</p> <p>Denominator = # of reviewed paid claims.</p>	<p>See FA-2</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Quarterly</p>	<p>See FA-2 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
<p>FA-4: The IME will measure the number of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology.</p> <p>Numerator: # of Capitation payments made to the MCOs at the approved rates through the CMS certified MMIS.</p> <p>Denominator: # of capitation payments made through the CMS certified MMIS.</p>	<p>See FA-2</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Quarterly</p>	<p>See FA-2</p>	<p>Data is Aggregated and Analyzed Quarterly</p>

State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS

Approved:

Attachment 3.1-C
 Page 55
 Supersedes: IA-17-003

--	--	--	--	--	--	--

<p>The state identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</p>	<p>HW-1: The IME will measure the total number and percent of IAC-defined major critical incidents requiring follow-up escalation that were investigated.</p> <p>Numerator = # of critical incidents that received follow-up as required;</p> <p>Denominator = # of critical incidents requiring follow-up escalation</p>	<p>100% of Incident Reports are reviewed The HCBS Quality Assurance unit and each MCO is responsible for monitoring and analyzing data associated with the major incidents reported for members on waivers. Data is pulled from the data warehouse and from MCO reporting on a regular basis for programmatic trends, individual issues and operational concerns. Reported incidents of abuse, medication error, death, rights restrictions, and restraints are investigated further by the HCBS Incident Reporting Specialist as each report is received. The analysis of this data is presented to the state on a quarterly basis.</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly,</p>	<p>The HCBS Incident Reporting Specialist and each MCO analyzes data for individual and systemic issues. Individual issues require communication with the case manager to document all efforts to remediate risk or concern. If a these efforts are not successful, staff continues efforts to communicate with the case manager, the case manager's supervisor, and protective services when necessary. All remediation efforts of this type are documented in the monthly and quarterly reports.</p> <p>The HCBS Specialists conducting interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. MCO are responsible for research and follow up to flagged responses.</p> <p>General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes to provider policy.</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
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State: Iowa

§1915(i) State plan HCBS

Attachment 3.1-C

TN: IA 18-014

Page 56

Effective: October 1, 2018

Approved: November 5, 2018

Supersedes: IA-17-003

		<p>The HCBS provider oversight unit, and each MCO, is responsible for conducting IPES interviews with waiver members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.</p>				
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State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 57
 Supersedes: IA-17-003

	<p>HW-2 The IME will measure Critical Incident Reports (CRIS) that identify a reportable event of abuse, neglect, exploitation, or unexplained death and were followed upon appropriately.</p> <p>Numerator = # of CIRs that identified a report was made to DHS protective services and/or appropriate follow up was initiated;</p> <p>Denominator = # of CIRs that identified a reportable event of abuse, neglect, exploitation, and/or unexplained death</p>	See HW-1 Above	Contracted Entity (Including MCOs)	Data is Collected Monthly,	See HW-1 Above	Data is Aggregated and Analyzed Quarterly
	<p>HW-3: The IME will identify all unresolved critical incidents which resulted in a targeted review and were completed to resolution.</p> <p>Numerator = # of targeted reviews resulting from an incident which were resolved within 60 days;</p> <p>Denominator = # of</p>	See HW-1 above	Contracted Entity (Including MCOs)	Data is Collected Monthly,	See HW-1 Above	Data is Aggregated and Analyzed Monthly, Quarterly and Annually

State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 58
 Supersedes: IA-17-003

	critical incidents that resulted in a targeted review					
	<p>HW-4: The IME will measure the total # & % of providers with policies for restrictive measures that are consistent with State and Federal policy and rules, and followed as written.</p> <p>Numerator = # providers reviewed that have policies for restrictive measures that were implemented as written;</p> <p>Denominator = total # of providers reviewed that identified having policies for restrictive measures.</p>	Provider's policies and procedures. 100% of all certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.	Contracted Entity (Including MCOs)	Data is Collected Monthly	<p>The Medical Services Unit utilizes criteria to grade each provider compliance area reviewed. If it is determined that the provider does not meet the standards for member's rights restrictions, the provider is notified of the deficiency and expectations for remediation. Providers submit a corrective action plan for any deficiency identified during the review..</p> <p>General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.</p>	Data is Aggregated and Analyzed Quarterly
	<p>HW-5 The IME will measure the number and percent of providers meeting state and federal requirements relative to individual waivers.</p> <p>Numerator = # of Quality Assurance reviews that did not receive a corrective action plan;</p>	Provider's policies and procedures. 100% of all certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.	Contracted Entity (Including MCOs)	Data is Collected Monthly	<p>The Medical Services Unit utilizes criteria to grade each provider compliance area reviewed. If it is determined that the provider does not meet the standards for member's rights restrictions, the provider is notified of the deficiency and expectations for remediation. Providers submit a corrective action plan for any deficiency identified during the review..</p> <p>General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.</p>	Data is Aggregated and Analyzed Quarterly

State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 59
 Supersedes: IA-17-003

	Denominator = # of provider Quality Assurance Reviews completed.					
An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.	<p>LC-1: Number and percent of new enrollees who had an evaluation indicating the individual 1915(i) eligible prior to receipt of services.</p> <p>Numerator: # of needs based eligibility reviews completed prior to the receipt of services</p> <p>Denominator: # of reviewed needs based eligibility reviews</p>	<p>The data informing this performance measure is pulled from ISIS and MCO data</p> <p>The Medical Services Unit performs internal quality reviews on a representative sample of the 1915(i) eligibility determinations that have been made with a 95% confidence level.</p>	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is collected quarterly	The state's Medical Services Unit performs internal quality reviews of initial and annual 1915(i) eligibility determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred the unit recommends that the service worker take steps to initiate a new 1915(i) eligibility determination through communication with the member and care coordinator. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.	Data is Aggregated and Analyzed Quarterly
An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.	<p>LC-2: IME will measure the number and percent of needs based eligibility decisions.</p> <p>Numerator: # of completed needs based eligibility reviews</p> <p>Denominator: # of referrals for needs based eligibility review</p>	<p>The data informing this performance measure is pulled from ISIS</p> <p>Reports are pulled and data is inductively analyzed at a 100% level.</p>	State Medicaid Agency & Contracted Entity	Data is collected monthly	See LC-1 above	Data is Aggregated and Analyzed Quarterly

State: Iowa

§1915(i) State plan HCBS

Attachment 3.1-C

TN: IA 18-014

Page 60

Effective: October 1, 2018

Approved: November 5, 2018

Supersedes: IA-17-003

<p>The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.</p>	<p>LC-3: The IME shall determine the number and percent of initial needs based eligibility decisions that were accurately determined by applying the approved needs based eligibility criterion using standard operating procedures.</p> <p>Numerator: # of needs based eligibility decisions that were accurately determined by applying the correct criteria as defined in the waiver;</p> <p>Denominator: # of reviewed needs based eligibility determinations.</p>	<p>The Medical Services Unit performs internal quality reviews on a representative sample of the 1915(i) eligibility determinations that have been made with a 95% confidence level. Data is reported on a quarterly basis and inductively analyzed.</p> <p>Data for completed needs based eligibility determinations is collected quarterly through reports generated through ISIS, MQUIDS, and OnBase. This data is monitored for trends from an individual and systems perspective to determine in procedural standards. Monthly a random sample of needs based eligibility decisions are selected from each reviewer. IQC activity is completed on the random sample. This level of scrutiny aids in early detection of variance from the stated needs based eligibility criteria</p>	<p>State Medicaid Agency & Contracted Entity</p>	<p>Data is collected Monthly</p>	<p>The state's Medical Services Unit performs internal quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred, the unit undertakes additional training for staff</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
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System Improvement:

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

Methods for Analyzing Data and	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System
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State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 61
 Supersedes: IA-17-003

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

State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 61a
 Supersedes: IA-17-003

<p>IME holds weekly policy staff and long term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff.</p> <p>Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance group gathers on a monthly basis to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. ISIS will only be utilized for fee-for-service members.</p>			<p>The IME employs a Quality Assurance Manager to oversee data compilation and remediation activities. The QA Manager and State policy staff address oversight of design changes and the subsequent monitoring and analysis during the weekly policy and monthly quality assurance meetings. Prior to dramatic system design changes, the State will seek the input of stakeholders and test/pilot changes that are suggested and developed. Informational letters are sent out to all relevant parties prior to implementation with contact information of key staff involved. This workflow is documented in logs and in informational letters found within the DHS computer server for future reference. Stakeholder involvement and informational letters are requested or sent out on a weekly/monthly/ongoing basis as policy engages in the continuous quality improvement cycle.</p>
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State: Iowa

§1915(i) State plan HCBS

Attachment 3.1-C

TN: IA 18-014

Page 62

Effective: October 1, 2018

Approved: November 5, 2018

Supersedes: IA-17-003

<p>All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas. The QM/QI program must have objectives that are measurable, realistic and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes.</p> <p>Finally, MCOs must meet the requirements of 42 CFR 438 Subpart E and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program.</p> <p>The State has developed a draft-reporting manual for the MCOs to utilize for many of the managed care contract reporting requirements, including HCBS performance measures. The managed care contract also allows for the State to request additional regular and ad hoc reports.</p>			<p>Based on contract oversight and performance measure implementation, the IME holds weekly policy staff and long term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff. Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement.</p> <p>Further, a quality assurance group gathers on a monthly basis to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. Data from QA/QI activities is also presented to the HCBS QA/AI Committee on a quarterly basis. The QA/QI Committee reviews the data makes recommendations for changes in policy to the 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 Committee also directs workgroups on specific activities of quality improvement and other workgroups are activated as needed.</p>
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State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 62A
 Supersedes: NEW

<p>Iowa acknowledges that improvements are necessary to capture data at a more refined level, specifically individual remediation. While each contracting unit utilizes their own electronic tracking system or OnBase (workflow management), further improvements must be made to ensure that there are not preventable gaps collecting individual remediation. The State acknowledges that this is an important component of the system; however the terrain where intent meets the state budget can be difficult to manage.</p> <p>The IME supports infrastructure development that ensures choice is provided to all Medicaid members seeking services and that these services are allocated at the most appropriate level possible. This will increase efficiency as less time is spent on service/funding allocation and more time is spent on care coordination and improvement. A comprehensive system of information and referrals ensures that all individuals are allowed fully informed choices prior to facility placement.</p> <p>A comprehensive system of information and referrals shall also be developed such that all individuals are allowed fully informed choices prior to facility placement. Many program integrity and ACA initiatives will assist in system improvements. These include improvements to provider screening at enrollment, tighter sanction rules, and more emphasis on sustaining quality practices.</p>			<p>The Committee is made up of certain HCBS Provider Quality Oversight staff and supervisors, 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 improvements are made.</p> <p>Finally, IME analyzes general system performance through the management of contract performance benchmarks, ISIS reports, and Medicaid Value Management reports and then works with contractors, providers, and other agencies regarding specific issues. HCBS Annual Reports are sent to the Iowa Association of Community Care Providers. Reports are also available to agencies, waiver providers, participants, families, and other interested parties upon request.</p>
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State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS

Approved: November 5, 2018

Attachment 3.1-C
 Page 62B
 Supersedes: New

<p>In accordance with 42 CFR 438.202, the State maintains a written strategy for assessing and improving the quality of services offered by MCOs including, but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries.</p>	<p>MCOs must comply with the standards established by the State and must provide all information and reporting necessary for the State to carry out its obligations for the State quality strategy. IME performs an annual review of each MCO. This is generally conducted at the time of the annual External Quality Review (EQR) and includes a determination of contract compliance, including that for fraud and abuse reporting and training. EQR is performed as federally required, and committee reports are reviewed during an annual visit. The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the State and authenticated as it can be used during onsite visits and through regular reports.</p>	<p>Reviews are Conducted Annually</p>	<p>The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the state and authenticated as it can be used during onsite visits and through regular reports. The Medical Services Unit contractor conducts an annual EQR of each managed care entity to ensure that they are following the outlined QA/QI plan.</p> <p>In addition to developing QM/QI programs that include regular, ongoing assessment of services provided to Medicaid beneficiaries, MCOs must maintain a QM/QI Committee that includes medical, behavioral health, and long-term care staff, and network providers. This committee is responsible for analyzing and evaluating the result of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action, and ensuring appropriate follow-up. This committee is also responsible for reviewing and approving the MCOs' QM/QI program description, annual evaluation, and associated work plan prior to submission to DHS.</p>
<p>All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas.</p>	<p>MCO QM/QI programs must have objectives that are measurable, realistic, and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. Finally, MCOs must meet the</p>	<p>Reviews are Conducted Annually</p>	<p>The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the state and authenticated as it can be used during onsite visits and through regular reports.</p>

State: Iowa
 TN: IA 18-014
 Effective: October 1, 2018

§1915(i) State plan HCBS
 Approved: November 5, 2018

Attachment 3.1-C
 Page 62C
 New

	<p>requirements of 42 CFR 438 subpart D and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program, and the State Medical Services conducts an annual EQR of each MCO to ensure that they are following the outlined QA/QI plan.</p>		
<p>MCOs must attain and maintain accreditation from the National Committee for Quality Assurance (NCQA) or URAC.</p>	<p>If not already accredited, the MCO must demonstrate it has initiated the accreditation process as of the MCO's contract effective date. The MCO must achieve accreditation at the earliest date allowed by NCQA or URAC. Accreditation must be maintained throughout the life of the MCO's contract at no additional cost to the State. When accreditation standards conflict with the standards set forth in the MCO's contract, the contract prevails unless the accreditation standard is more stringent.</p> <p>MCOs must meet the requirements of 42 CFR 438 subpart D and the standards of the credentialing body by which the MCO is credentialed.</p>	<p>Reviews are Conducted Every Three Years</p>	<p>NCQA and URAC 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 start rating comprised of five categories (access and service, qualified providers, staying health, getting better, living with illness).</p>