*An IHH can choose to adopt the following policy and procedure for person-centered planning with the condition that the IHH / organization will review and keep the policy updated with knowledge and information in the Code of Federal Regulations, Iowa Administrative Code, State Plans, Provider Manuals, Contracts and policy and procedures specific to the IHH / organization.

Revised January 2024

Policy and Procedure

1915(i) Habilitation and 1915(c) Children's Mental Health Waiver: Person-Centered Planning and Documentation Requirements

This policy and procedure reviews requirements for the person-centered planning process, the person-centered service plan, Home-and Community-Based settings, and monitoring of the person-centered service plan. These requirements can also be found in the Code of Federal Regulations, Iowa Administrative Code, State Plans, Provider Manuals, Contracts, National Committee for Quality Assurance (NCQA) LTSS Standards for Delegation, and policy and procedures specific to this organization.

Refer specifically to the Health Home State Plan Amendment for guidelines on providing the six core Health Home services to members with Habilitation eligibility and Children's Mental Health Waiver.

Overview of Person-Centered Planning[3]

Service planning for participants in Medicaid HCBS programs, including 1915(i) Habilitation and 1915(c) Children's Mental Health waiver, must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs and may include a representative that the individual has freely chosen, and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences, including those related community participation, employment, income and savings, health care and wellness, education and others. The plan should reflect the services and supports (paid and unpaid), who provides them and whether an individual chooses to self-direct services. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare.

Eligibility and Assessment Phase

To be eligible for Habilitation, an individual must meet the criteria defined in Iowa Administrative Code 441-78.27(2). As part of this criteria, a needs assessment is completed. The needs assessment and other supporting documentation as relevant are used to determine habilitation eligibility. The approved needs assessments include:

Youth aged 18 and younger	Individuals aged 19 and older
Comprehensive Assessment and Social History (CASH) and Child and Adolescent Level of Care Utilization System (CALOCUS)	Comprehensive Assessment and Social History (CASH) and Level of Care Utilization System (LOCUS)

To be eligible for Children's Mental Health Waiver, an individual must meet the criteria defined in Iowa Administrative Code 441-83.122(249A) and follow the application process as defined by 441-83.123(249A). When the number of applicants exceeds the number of individuals specified in the approved waiver, the individual's application is rejected, and the individual's name is placed on a waiting list.[12] The IHH should ensure that individuals are receiving additional non-waiver supports and services while on the waiting list.[15]

As part of the eligibility criteria for Children's Mental Health Waiver, an assessment is completed. The assessment and other supporting documentation are used to determine eligibility. The approved assessments include:

For children aged 3 or under	Individuals aged 4 to 11	Individuals aged 12 – 18
Form 470-4694, Case Management Comprehensive Assessment	interRAI Child and Youth Mental Health (ChYMH)	interRAI Child and Youth Mental Health (ChYMH) and Adolescent Supplement

Assessments are completed to determine the need for any medical, social, educational, housing, transportation, vocational, or other services. Assessments and reassessments should address the member's areas of need, strengths, preferences, and risk factors, considering the person's physical and social environment. Reassessments occur, at minimum, every 365 days and more often if material changes occur in the member's condition or circumstances.[13]

For both Habilitation and Children's Mental Health Waiver, the Integrated Health Home Care Coordinator is responsible for:

(1) Arranging for the completion of the assessment, before services begin and annually thereafter. [10]
    a. Members should receive prior notification of the assessment tool to be used and of who will conduct the assessment.[13]
    b. Assessments should be completed face-to-face.[13]
(2) Using the information in the assessment and other supporting documentation as relevant to develop a person-centered service plan, before services begin and annually thereafter.[10]

The eligibility and assessment phase activities should also include the following:[10, 12, 13]

1) Taking the member's history, including current and past information and social history in accordance with Iowa Administrative Code 441-24.4(2), and updating the history annually.
2) Identifying the needs of the member and completing related documentation.
3) Gathering information from other sources, such as family members, medical providers, social workers, legally authorized representatives, and others as necessary to form a complete assessment of the member.
4) Assessment of health, functioning, and communication needs including:[16]
    a. Health status, including condition-specific issues
    b. Clinical history, including medications
    c. Activities of daily living, including use of supports
    d. Instrumental activities of daily living, including use of supports
    e. Behavioral health status

    f. Cognitive functioning
    g. Social determinants of health
    h. Social functioning
    i. Health beliefs and behaviors
    j. Cultural and linguistic needs, preferences, or limitations
    k. Visual and hearing needs, preferences, or limitations
    l. Physical environment for risk
5) Resource assessment including:[16]
    a. Paid and unpaid caregiver resources, involvement and needs
    b. Available benefits within the organization
    c. Community resources
6) Person-centered assessments including:[16]
    a. Assess members' service needs
    b. Assess members' prioritized goals
    c. Assess members' preferences
    d. Assess members' life planning activities
    e. Identify members' preferred method of communication

Assessment Administration Requirements

The IM/MCO Learning Collaborative provides annual assessment administration training in which participation is required for IHH care coordinators. The training is recorded for IHH use with new hires, etc. IHHs should refer to the interRAI Children and Youth Mental Health manual and Instructions for Completing the Comprehensive Assessment and Social History to facilitate an accurate and uniform assessment.

IHHs are responsible for implementing a quality assurance program to ensure the accuracy of assessments.

Further assessment requirements include:[15]

1) Members will have the ability to have others present of their choosing;
2) Members and chosen team members will receive notice to schedule no less than 14 days prior to current assessment end date;
3) Members and chosen team members will receive a copy of the completed assessment within three (3) business days of the assessment;
4) Members and chosen team members will receive information related to the assessment results in a manner that is meaningful to the team;
5) Assessments should be conflict-free and firewalled from case management and utilization management functions;
6) Assessors should be trained either by the organization that developed the assessment tool or by an individual directly trained by the organization that developed the assessment tool;
7) Assessors should be trained in appropriate administration of the identified assessment tool in line with best practice for the tool administered;
8) Assessment results should be drawn using a valid sample size to evaluate the inter-rater reliability of the assessment administration; and

9) Any assessment determined to be inappropriately derived during evaluation should be re-administered within 30 days of findings.

Redetermination

Habilitation and Children's Mental Health (CMH) waiver eligibility redetermination / reassessments occur, at minimum, every 365 days and more often if material changes occur in the member's condition or circumstances.[10,12,13]

Integrated Health Homes (IHHs) should submit required paperwork to the appropriate Managed Care Organization (MCO) for Habilitation and CMH waiver eligibility initial and renewal requests.

For members seeking Habilitation eligibility or renewal, the MCO Assessment Team will complete the LOCUS / CALOCUS. The LOCUS / CALOCUS is based off the comprehensive assessment and social history (CASH) that has been updated within the past 60 business days. Additional documentation may also be submitted with the CASH for review. The LOCUS / CALOCUS report is uploaded to IMPA and the IHH will access it there.

The MCO uploads initial requests to Iowa Medicaid (IM) for initial determination.[15] IM has final review and approval for any reassessments that indicate a change in the level of care.[15]

Integrated Health Homes should notify the service provider and member / family when an eligibility has been approved.[10, 12]

Person-Centered Planning Process

Based on the independent assessment (i.e., interRAI assessment, Comprehensive Assessment and Social History), the Integrated Health Home Care Coordinator must develop a written service plan jointly with the individual (including, for purposes of this paragraph, the individual and the individual's authorized representative if applicable) and interdisciplinary team. The interdisciplinary team must include the member, integrated health home, provider, and other persons designated by the member. Other persons on the team may be:

- The parents when the member is a minor.
- The member's legally authorized representative.
- The member's family, unless the family's participation is limited by court order or is contrary to the wishes of the adult member who has not been legally determined to be unable to make decision independently.
- All current service providers.
- Any other professional representation including, but not limited to:
    - Vocational rehabilitation counselors,
    - Court appointed mental health advocates,
    - Correction officers,
    - Educators, and
    - Other professionals as appropriate.
- Persons identified by the member or family, provided the family's wishes are not in conflict with the desires of the member.[5]

Person-centered planning is implemented in a manner that supports the member, makes the member central to the process, and recognizes the member as the expert on goals and needs. For this to occur, there are certain process elements that must be included in the process.[13]

The person-centered planning process is driven by the individual. The process:

(1) Includes people chosen by the individual.[6, 7]
- The member, guardian or representative must have control over who is included in the planning process, as well as have the authority to request meetings and revise the person-centered service plan (and any related budget) whenever reasonably necessary.[13]

(2) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions.[6, 7]
- Necessary information and support are provided to ensure that the member or the member's guardian or representative is central to the process and understands the information. This includes the provision of auxiliary aids and services when needed for effective communication.[13]
- The planning process should not be constrained by any case manager's or guardian's or representative's preconceived limits on the member's ability to make choices[13]

(3) Is timely and occurs at times and locations of convenience to the individual.[6,7]
- The process is timely and occurs at times and locations of convenience to the member, the member's guardian or representative and family members, and others, as practicable.[13]

(4) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.[6,7]
- The member's cultural preferences must be acknowledged in the planning process, and policies/practices should be consistent with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) of the Office of Minority Health, U.S. Department of Health and Human Services.[13]
- The planning process must provide meaningful access to members and their guardians or representatives with limited English proficiency (LEP), including low literacy materials and interpreters.[13]

(5) Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.[6,7]
- There shall be mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines.[13]

(6) Offers choices to the individual regarding the services and supports the individual receives and from whom.[6,7]
- Members shall be offered information on the full range of HCBS available to support achievement of personally identified goals.[13]
- The member or the member's guardian or representative shall be central in determining what available HCBS services are appropriate and will be used.[13]
- The member shall be able to choose between providers or provider entities, including the option of self-directed services when available.[13] (self-directed or Consumer Choice Options are not applicable to Habilitation or CMH waiver eligibility).

(7) Includes a method for the individual to request updates to the plan, as needed.[6,7]
   - The person-centered service plan shall be reviewed at least every 365 days or sooner if the member's functional needs change, circumstances change, or quality of life goals change, or at the member's request. There shall be a clear process for members to request reviews. The case management entity must respond to such requests in a timely manner that does not jeopardize the member's health or safety.[13]

(8) Records the alternative home and community-based settings that were considered by the individual.[6,7]
   - Employment and housing in integrated settings shall be explored, and planning should be consistent with the member's goals and preferences, including where the member resides and with whom the member lives.[13]

Additionally, the process will:

(1) Identify who the member selects as the team lead. The member will lead the process where possible.[1, 6, 7, 15]
(2) Include a discussion of options for meaningful day activities, employment, and educational opportunities.[8]
(3) Allow for the comprehensive service plan to be completed and approved before services are provided.[10, 3]
(4) Utilize a strengths-based approach to identifying the positive attributes of the member, including an assessment of the member's strengths and needs. The member is able to choose the specific planning format or tool used for the planning process.[13]
(5) Consider the member's personal preferences to develop goals and to meet the member's HCBS needs.[13]
(6) Members who are under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, must have the opportunity in the planning process to address any concerns.[13]
(7) Further address the following:[16]
   a. Development of an individualized case management plan that includes services needed, members' preferences, and prioritized goals.
   b. Identification of barriers to meeting members' goals and preferences or implementing the plan
   c. Development of a schedule for follow-up and communication with members
   d. Development of a plan for follow-up and communication with LTSS providers
   e. Development of an emergency back-up plan
   f. Development of a self-management plan
   g. Facilitation of referrals to resources and a follow-up process to determine whether members acted on referrals.
   h. A process to capture whether members received services identified in the case management plan.
   i. A process to assess members' progress against case management plans, at least every 12 months.

Person-Centered Service Plan

A member with habilitation eligibility or Children's Mental Health waiver eligibility must have a comprehensive person-centered service plan. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need (i.e. interRAI assessment, Comprehensive Assessment and Social History), as well as what is important to the individual with regard to preferences for the delivery of those services and supports.[6, 7]

The interdisciplinary team must convene to develop the initial service plan and revise the service plan, at least annually or whenever there is significant change in the items addressed in member's needs or conditions.[5]

The member's integrated health home care coordinator prepares the comprehensive person-centered service plan. HCBS habilitation and CMHW service providers must complete their own service plan that provides detailed information on how they will implement the services for the member. These plans must reflect the comprehensive person-centered service plan and comply with the provider's licensure and accreditation requirements as applicable.[4]

Considering the level of need of the individual and the scope of services and supports available under Habilitation or Children's Mental Health Waiver, ***the written plan must***:

(1) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in and supports full access of individuals receiving Medicaid HCBS 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 to the same degree of access as individuals not receiving Medicaid HCBS.[6, 7, 13]

(2) Reflect the individual's strengths and preferences.[6, 7]
   - Note the strengths-based positive attributes of the member at the beginning of the plan.[13]

(3) Reflect clinical and support needs as identified through an assessment of functional need.[6,7]

(4) Include individually identified goals and desired outcomes.[6,7]

(5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS.[6,7]
   - Document goals in the words of the member or the member's guardian or representative, with clarity regarding the amount, duration, and scope of HCBS services that will be provided to assist the member. Goals shall consider the quality-of-life concepts important to the member.[13]
   - Describe the services and supports that will be necessary and specify what HCBS services are to be provided through various resources, including natural supports, to meet the goals in the person-centered service plan.[13]

- Document the specific person or persons, provider agency and other entities providing services and supports.[13]
- Document non-paid supports and items needed to achieve the goals.[13]

(6) Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.[6, 7]
    - Identify risks, while considering the member's right to assume some degree of personal risk and include measures available to reduce risks or identify alternate ways to achieve personal goals.[13]
    - Ensure the health and safety of the member by addressing the member's assessed needs and identified risks.[13]
    - Document an emergency back-up plan that encompasses a range of circumstances (e.g., weather, housing, and staff).[13]

(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b).[6,7]
    - Be prepared in person-first singular language and be understandable by the member or the member's guardian or representative.[13]

(8) Identify the individual and/or entity responsible for monitoring the plan.[6,7]
    - Identify each person and entity responsible for monitoring the plan's implementation.[13]

(9) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.[6,7]
    - Include the signatures of everyone with responsibility for the plan's implementation, including the member or the member's guardians or representatives, the case manager, the support broker/agent (when applicable), and providers, and include a timeline for review of the plan. The plan must be discussed with family, friends, and caregivers designated by the member so that they fully understand it and their roles.[13]

(10) Be distributed to the individual and other people involved in the plan.[6,7]
    - Be distributed directly to all parties involved in the planning process.[13]

(11) Prevent the provision of unnecessary or inappropriate services and supports.[6,7]
    - Identify needed services based upon the assessed needs of the member and prevent unnecessary or inappropriate services and supports not identified in the assessed needs of the member.[13]

(12) Document that any modification of the additional conditions, under 42 CFR 441.710(a)(1)(vi) ust be supported by a specific assessed need and justified in the person-centered service plan.[6,7]
    - Any effort to restrict the rights of a member to realize the member's preferences or goals must be justified by a specific individualized assessed safety need and documented in the person-centered service plan. The following requirements must be documented in the plan when a safety need has been identified that warrants a rights restriction:[6,7,13]
        a. Identify a specific and individualized assessed need.

b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
c. Document less intrusive methods of meeting the need that have been tried but did not work.
d. Include a clear description of the condition that is directly proportionate to the specific assessed need.
e. Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
g. Include informed consent of the individual; and
h. Include an assurance that the interventions and supports will cause no harm to the individual.

42 CFR 441.710(a)(vi)(A) through (D)

In a provider-owned or controlled residential setting, in addition to the above qualities, the following additional conditions must be met:

(1) 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, the State must ensure that a lease, residency agreement or other form of written agreement will be 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;
(2) Each individual has privacy in their sleeping or living unit:
    a. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors;
    b. Individuals sharing units have a choice of roommates in that setting; and
    c. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
(3) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;
(4) Individuals are able to have visitors of their choosing at any time

Additionally, the person-centered service plan will:

(1) Include a plan for emergencies and identification of the supports available to the member in an emergency including the member’s risk assessment, the emergency backup support and crisis response system identified by the Interdisciplinary Team, and emergency backup staff for all applicable services.[1, 2, 4, 5, 6, 7, 10, 15]
(2) Include identified activities to encourage the individual to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.[1, 10, 15]
(3) Include information specific to Employment Services:[4]

a. Identify the individual's prevocational or supported employment setting.
b. Prevocational services – Where the individual is earning subminimum wages, include documentation in the written plan that counseling, information, and referral regarding integrated community employment has been provided.
c. Small group employment – include the number of members working in the group with the member and the number of hours of work per week.
d. Individual supported employment – include the number of hours of employment per week and the number of hours of on-site staff support needed by the member per week.

(4) Include information specific to home-based habilitation:[10]
  a. The individual's living environment at the time of 1915(i) enrollment
  b. The number of hours per day of onsite staff supervision needed by the individual.
  c. The number of other waiver members who will live / do live with the member in the living unit.

(5) Indicate the individual was informed of how to report suspected abuse, neglect, or exploitation.[2, 4]

(6) Include interventions and supports needed to meet the individual's goals and incremental action steps as appropriate.[5, 10, 15]
  a. For Habilitation: refer to IAC 441-78.27 for scope of services and covered supports.
  b. For Children's Mental Health Waiver, refer to IAC 441-78.52 for scope of services and covered supports.

(7) Reflect the timeframe, frequency, funding source, and the number of units / amount of services to be received by the individual.[1, 2, 4, 5, 10, 15]

(8) Include services identified to meet the needs of the individual which the individual declined to receive.[5]

(9) Include services appropriate to the severity level of problems and specific needs or disabilities.[8, 10, 15]

(10) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.[8, 10]

Home and Community-Based Settings

A Home- and Community-Based Services (HCBS) Residential Setting Member Assessment, form 470-5466, is completed annually for each member accessing 1915(i) Habilitation and 1915(c) Children's Mental Health Waiver services. If applicable, the information from the assessment is included on the member's person-centered plan.[14]

According to Federal Code of Regulations, Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary of Health and Human Services determines to be appropriate, based on the needs of the individual **as indicated in their person-centered service plan**:[6, 7]

(1) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS 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, to the same degree of access as individuals not receiving Medicaid HCBS.

(2) The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

(3) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(4) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

(5) Facilitates individual choice regarding services and supports, and who provides them.

(6) *In a provider-owned or controlled residential setting*, in addition to the qualities at §441.301(c)(4)(i) through (v) / §441.710, the following additional conditions must be met:

  a. 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, the State must ensure that a lease, residency agreement or other form of written agreement will be 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.

  b. Each individual has privacy in their sleeping or living unit:

    i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

    ii. Individuals sharing units have a choice of roommates in that setting.

    iii. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(7) Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

(8) Individuals are able to have visitors of their choosing at any time.

(9) The setting is physically accessible to the individual.

(10) Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D) / §441.710, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

  a. Identify a specific and individualized assessed need.

  b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

  c. Document less intrusive methods of meeting the need that have been tried but did not work.

  d. Include a clear description of the condition that is directly proportionate to the specific assessed need.

  e. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
g. Include the informed consent of the individual.
h. Include an assurance that interventions and supports will cause no harm to the individual.

Additionally, for members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan will address the member's opportunities for independence and community integration.[10]

Home and community-based settings do not include the following:[6, 7]

(1) A nursing facility;
(2) An institution for mental diseases;
(3) An intermediate care facility for individuals with intellectual disabilities;
(4) A hospital; or
(5) Any other locations that have qualities of an institutional setting, as determined by the Secretary of Health and Human Services. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

Review of the Person-Centered Service Plan

The person-centered service plan must be reviewed, and revised upon reassessment of functional need (i.e. interRAI assessment or LOCUS), at least every 365 days, or sooner if the member's functional needs change, circumstances change, or quality of life goals change, or at the member's request. [1, 2, 4, 5, 6, 7, 10, 12, 13, 15] There should be a clear process for members to request reviews. The care coordinator must respond to requests in a timely manner that does not jeopardize the member's health or safety.[13]

In addition, the person-centered plan should be revised on or before the current comprehensive service plan expires.[1, 2, 10]

IHH should follow regulatory reporting specifications to report timely and untimely care plans.

Pre-Authorization of Habilitation and Children's Mental Health Waiver Services

Preapproval is required for Habilitation and Children's Mental Health waiver eligibility and services.[17] For home-based habilitation, the LOCUS / CALOCUS determines the home-based habilitation tier. Integrated Health Homes will notify the service provider and member / family when eligibility or service request has been approved.[10, 12]

Referrals, Monitoring of Person-Centered Plan, and Contacts

The care coordinator should complete activities and make contacts that are necessary to ensure the health, safety, and welfare of the individual.

Referrals

The care coordinator should assist, as needed, the member in obtaining needed services. This may include scheduling appointments for the member and connecting the member with medical, social, educational, housing, transportation, vocational, or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals in the person-centered service plan.[13]

Monitoring

The care coordinator should complete activities and make contacts that are necessary to ensure the health, safety, and welfare of the individual and to ensure that the service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring includes assessment the member, the place of service (including the member's home, when applicable), and all services regardless of the service funding stream. Monitoring also includes review of service provider documentation. Monitoring of the following aspects of the person-centered service plan should lead to revisions of the plan if deficiencies are noted:[13]

(1) Services are being furnished in accordance with the member's person-centered service plan, including the amount of service provided and the member's attendance and participation in the service;
(2) The member has declined services in the service plan;
(3) Communication among providers is occurring, as practicable, to ensure coordination of services;
(4) Services in the person-centered plan are adequate, including the member's progress toward achieving the goals and actions determined in the person-centered service plan; and
(5) There are changes in the needs or circumstances of the member. Follow-up activities include making necessary adjustments in the person-centered service plan and service arrangements with providers.

Provider Service Documenation Review

IHH Care coordinator will review the member's service record maintained by the HCBS service provider(s) including but not limited to the following:

(1) Service plan
(2) Service logs, notes or narratives
(3) Mileage and transportation logs
(4) Financial records, invoices or receipts
(5) Medications and the medication administration record (MAR)
(6) Incident reports
(7) Other service documentation as applicable to identify gaps in care, environmental issues, health and welfare issues etc.
(6)

Contacts

Care coordinators contact members, the members' guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary.[13] Contact requirements include:

(1) Contacting the individual, either in-person or by phone, within five (5) business days of scheduled initiation of services to confirm that services are being provided and that the individual's needs are being met.[15]
(2) Monthly contacts: The care coordinator contacts the individual, or the individual's guardian or representative, at least monthly either in person or by telephone. [13,15,18]
(3) Quarterly contacts: The care coordinator visits the individual in their residence face-to-face at least quarterly.[13,15, 18]

Transitions of Care

The Integrated Health Home works to reduce unplanned transitions by managing transitions and identifying problems that can result in transitions of care including:[16]

(1) Identify members who transition between settings
(2) Notify members' usual providers of a transition within a specified time frame
(3) Assign a consistent person or unit within the organization responsible for supporting a member throughout a transition within a specified timeframe
(4) Communicate necessary information with the receiving setting within a specified time frame
(5) Communicate the care transition process to members and their designated representatives within a specified time frame
(6) Track transition status
(7) Collaborate with the discharge team on the discharge plan
(8) Reassess the appropriateness of an existing case management plan within a specified time frame, and modify as needed
(9) Discuss changes to the case management plan with members and their designated representatives within a specified time frame
(10) Document medications with members and their designated representatives and communicate identified discrepancies to an appropriate provider

Additionally, the transitions of care process reduces unplanned transitions for members by:[16]

(1) Identifying members at high risk of an unplanned transition, at least monthly
(2) Taking action to mitigate risk of unplanned transitions.

And further reduces unplanned transitions for the population by:[16]

(1) Analyzing rates of unplanned admissions to facilities and emergency room visits, to identify areas for improvement.
(2) Taking action to address areas identified for improvement.

Incident Reporting

When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member should notify the following persons of the incident by midnight of the next calendar day after the incident:

a. The staff member's supervisor
b. The member or member's legal guardians; and
c. The member's care coordinator. The care coordinator should create and incident report if a provider has not submitted a report.

Minor and major incidents, as defined by Iowa Administrative Code,[8, 9, 13, 15] should be reported to the MCO / IM by the staff member involved or who witnessed the incident by midnight of the next business day after the incident; however, the care coordinator is ultimately responsible for reporting the incident if the provider of the service has not already reported the incident.[13]

All critical incidents, regardless of MCO affiliation, will be submitted in IMPA (Iowa Medicaid Portal Access). Incident reports should be kept in the member's record in accordance with Iowa Administrative Code 441-79.3.

The IHH should track incident data and analyze trends to assess the health and safety of members served and to determine whether changes need to be made for service implementation or whether staff training is needed to reduce the number or severity of incidents.[13]

When an incident report for a major incident is received from any provider, the care coordinator will monitor the situation to ensure the member's needs continue to be met. When any major incident occurs, the care coordinator should reevaluate the risk factors identified in the risk assessment portion of the service plan in order to ensure the continued health, safety, and welfare of the member. Documentation must be made in the person-centered service plan of this review and follow-up activities.[13]

All information related to immediate resolution as it pertains to the health and safety of everyone involved in the incident, should be documented as part of the immediate resolution section of the critical incident report. All long term resolutions and remediation plans should be documented in the corresponding section of the critical incident report.

Children's Mental Health Waiver or Habilitation Termination

A member may choose to end the Children's Mental Health (CMH) waiver or Habilitation eligibility at any time. Additional reasons for terminating CMH waiver or Habilitation eligibility and services are outlined below.

Members with CMH waiver eligibility must show a need for service and receive, at minimum, one billable unit of a CMH waiver service per calendar quarter.[12] To inquire about the exception to policy (ETP) for CMH waiver through Wellpoint, email IA-HealthHome@wellpoint.com . For Iowa Total Care, email ITC_IHH@iowatotalcare.com.

A child's waiver eligibility will continue until one of the following conditions occurs:

(8) The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).
(9) The consumer is an inpatient of a medical institution for 120 or more consecutive days.
    a. After the consumer has spent 120 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

b. If the consumer returns home after 120 consecutive days, the consumer must reapply for children's mental health waiver services, and the IM medical services unit must redetermine the consumer's level of care.

(3) The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.[12]

Additional reasons CMH waiver eligibility and services may be terminated include:[12]

(1) The provisions of 441—paragraph 130.5(2)"a," "b," "c," "g," or "h" apply.
(2) The costs of the children's mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6)"c."
(3) The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 120 days in any one stay.
(4) The physical or mental condition of the consumer requires more care than can be provided in the consumer's own home, as determined by the consumer's case manager or integrated health home care coordinator.
(5) Service providers are not available.

The member's HHS Income Maintenance worker should be notified of CMH waiver eligibility closures. If MCO is not already aware of the closure, the MCO should also be notified via the Health Home notification form.

Termination of Habilitation eligibility and services include the following reasons:[10]

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.
(2) The service is not identified in the member's comprehensive service plan.
(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.
(4) The member's service needs are not being met by the services provided.
(5) The member has received care in a medical institution for 120 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 120 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.
(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.
(7) Duplication of services provided during the same period has occurred.
(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.
(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

Both Wellpoint and Iowa Total Care should be notified of Habilitation eligibility closure via the Health Home notification form.[19]

Staff Member Attestation

I have read the above policy and procedure and know where to find this policy and procedure again when needed.

Name printed	Signature	Date

Review of Person-centered Planning Policy and Procedure

This policy and procedure will be reviewed, at minimum, annually and updated accordingly by this provider organization / IHH.

Date Reviewed	Name of Reviewer	Description of Revisions

References

1 1915(c) State Plan HCBS Children's Mental Health (CMH) Waiver. Accessed online: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/policies-rules-and-regulations/home-and-community-based-services-hcbs-waivers-program

2 1915(i) State Plan HCBS Habilitation Program: Quality Improvement Strategy, Approved September 21, 2017. Accessed online: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/habilitation-services

3 Centers for Medicare & Medicaid Services, Home and Community Based Services, HCBS 1915(i) fact sheet. Accessed online: https://www.medicaid.gov/sites/default/files/2019-12/1915c-fact-sheet_0.pdf4 Department of Human Services Habilitation Services Provider Manual. Accessed online: https://dhs.iowa.gov/policy-manuals/medicaid-provider

5 Department of Human Services Home- and- Community-Based Services (HCBS) Provider Manual. Accessed online: https://dhs.iowa.gov/sites/default/files/HCBS.pdf

6 Federal Code of Regulations. Chapter 441, Sub-part M- State Plan Home and Community-Based Services for the Elderly and Individuals with Disabilities, 79 FR 3033, Jan. 16, 2014, unless otherwise noted, 441.700 – 441.725(c)

7 Federal Code of Regulations. Chapter 441, Sub-part G- Home and Community-Based Services: Waiver Requirements, 46 FR 48541, Oct 1, 1981, unless otherwise noted, FCR current as of Aug 24, 2018, 441.300 – 441.310

8 Iowa Administrative Code, Human Services Department 441, Chapter 24. Accessed online: https://www.legis.iowa.gov/law/administrativeRules

9 Iowa Administrative Code, Human Services Department 441, Chapter 77. Accessed online: https://www.legis.iowa.gov/law/administrativeRules

10 Iowa Administrative Code, Human Services Department 441, Chapter 78. Accessed online: https://www.legis.iowa.gov/law/administrativeRules

11 Iowa Administrative Code, Human Services Department 441, Chapter 79. Accessed online: https://www.legis.iowa.gov/law/administrativeRules

12 Iowa Administrative Code, Human Services Department 441, Chapter 83. Accessed online: https://www.legis.iowa.gov/law/administrativeRules

13 Iowa Administrative Code, Human Services Department 441, Chapter 90. Accessed online: https://www.legis.iowa.gov/law/administrativeRules

14 Iowa Department of Human Services, Informational Letters, 1842-MC-FFS Home-and Community-Based Services (HCBS) Residential Setting Member Assessment, 11/03/2017. Accessed online: https://hhs.iowa.gov/media/2895/download?inline=

15 Managed Care Contract and Amendments, Wellpoint, 3.2.11 and 4.4 Accessed online: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/medicaid-contracts

16 National Committee for Quality Assurance. LTSS Standards for Health Plans- Delegation. Accessed online: https://ncqa.org

17 Provider Manual- Wellpoint. Accessed online: https://www.provider.wellpoint.com/iowa-provider/home

18 State Plan Amendment – Health Home. Accessed online: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/current-projects/meme

19 Supplemental Manual- Wellpoint Health Home Program Supplemental Provider Manual

https://www.provider.wellpoint.com/docs/gpp/IA_CAID_PF_HealthHomeSupplemental.pdf?v=202204041824A