Iowa | Medicaid

Long-term services and supports

Provider orientation 2024

Wellpoint | Iowa Health Link Iowa HHS

What are long-term services and supports (LTSS)?

Long-term services and supports (LTSS) are:

- Specific services provided to members living in their community or residing in a long-term care facility.

LTSS occurs in two settings:

- Home- and community-based services (HCBS):
  - Services provided in the member's home or in a community setting
- Long-term care facility:
  - Nursing facility (NF) or intermediate care facility for intellectually disabled (ICF/ID)

LTSS program quality goals

Goal one: person-centered services and supports — Develop service plans and deliver quality services in a manner that is person-centered, participant-driven, holistic, involves caregivers, and addresses social determinants of health (SDOH).

Goal two: smooth transitions — Ensure continuity of care and seamless experiences for participants as they transition into the HCBS waiver programs or among providers, settings, or coverage types.

Goal three: access to services (member choice) — Assure timely access to appropriate services and supports to ensure participants live in their setting of choice and promote their well-being and quality of life.

Home- and community-based (HCBS) waiver services

What are HCBS services?

Medicaid home- and community-based services (HCBS) are:

- Federally approved waiver and community-based programs.
- Available to members who meet specific requirements.
- Provided in the member's home or community setting.
- Administered by the state Medicaid agency:
  - Programs may vary from state to state.

Iowa has seven HCBS waiver programs

Each waiver program targets a specific population with a menu of services to meet identified needs:

- Acquired immune deficiency syndrome/human immunodeficiency virus (AIDS/HIV) waiver
- Brain injury (BI) waiver
- Children's mental health (CMH) waiver
- Elderly (EW) waiver
- Health and disability (HD) waiver
- Intellectual disability (ID) waiver
- Physical disability (PD) waiver

Who can receive HCBS waiver services?

HCBS services are not available to everyone who receives Medicaid:

- Waiver services are an expanded benefit under the state Medicaid plan.
- Each waiver program has a specific menu of services.
- Services are provided to meet the member's needs and not for the convenience of the provider and/or caregiver(s).

HCBS waiver programs are available for members who meet certain criteria:

- Level of care
- Income and resource limitations
- Age, disability, and/or medical need
- Need for HCBS waiver services
- Services must not exceed the established cost limit for the member's level of care.

Accessing HCBS services

Before HCBS services can begin:

- The member is assigned an HCBS waiver payment slot by Iowa Medicaid.
- Member needs have been assessed for services to assist with daily living activities:
  - Standardized assessment(s) completed annually
- The person-centered planning team meets with the member to identify services to meet the individuals' assessed needs.
- The person-centered service plan (PCSP) is developed by the case manager based on the member's goals and input received from the person-centered planning team, and other needed documents have been completed.
- Iowa Medicaid-approved Wellpoint provider is identified through the above person-centered planning process.
- Services have been approved.

What services are available for HCBS waivers?

A variety of services are available to support the needs of the member. Some of these services include, but not limited to:

- Adult day care
- Assisted living service
- Assistive devices
- Chore services
- Consumer choices option
- Consumer-directed attendant care (CDAC)
- Day Habilitation
- Family and community support
- Home-delivered meals
- Home health aide
- Homemaker
- Home/vehicle modification
- Interim medical monitoring & treatment (IMMT)
- Medical daycare for children
- Mental health outreach
- Personal emergency response system (PERS)
- Prevocational services
- Respite care
- Senior companion
- Specialized medical equipment
- Supported community living (SCL)
- Supported employment
- Transportation

Home- and community-based (HCBS) habilitation services

Habilitation services

Habilitation services are designed to:

- Assist members with functional impairments typically associated with chronic mental illnesses.
- Assist members in acquiring, retaining, and improving self-help, socialization, and adaptive skills to live successfully in a community setting.

Habilitation services are available to members who meet certain requirements:

- Income and resource limitations
- Are eligible for Medicaid
- Have an assessed need for a habilitation service
- Have specific risk factors

Note: Services are included in the member's person-centered comprehensive service plan.

What services are available under habilitation services?

Iowa Medicaid allows for the following services to be provided under habilitation services:

- Case management:
  - Only allowed if a member is not enrolled in an integrated health home or a Medicaid-targeted case management program
- Home-based habilitation
- Day habilitation
- Prevocational habilitation
- Supported employment:
  - Individual employment support
  - Supported self-employment
  - Small group employment

Requirements for habilitation service providers

All providers of habilitation services must:

- Be enrolled by Iowa Health and Human Services (HHS) to provide habilitation services.
- Comply with requirements regarding organizational staff as directed in *441 IAC 77.24(2)*.
- Adhere to requirements for incident management and reporting found in *441 IAC 77.24(3)*.
- Follow requirements for restraint, restrictions, and behavioral interventions in *441 IAC 77.24(4)*.
- Follow standards set forth in *441 IAC 79.3(249A)* for service documentation and maintenance of records.

Residential settings must:

- Comply with the settings requirements directed by CMS.
- Reimburse for services within the established Medicaid rate limit.
- Follow established guidelines and protocols for resources and sharing of services.

Community-based neurobehavioral rehabilitation services (CNRS)

Community-based neurobehavioral rehabilitation services (CNRS)

Community-based neurobehavioral rehabilitation services (CNRS) are specific, functional rehabilitative services provided by a multidisciplinary team for individuals diagnosed with a brain injury.

Member eligibility requirements for CNRS:

- Having a current brain injury and mental health diagnosis
- Having an assessed need for services
- Showing risk factors listed in *441 IAC 78.56(2)*
- Having a comprehensive neurobehavioral assessment completed by a qualified professional within 90 days of admission

Note: Services are included in a person-centered service plan.

What services are available under CNRS?

Residential CNRS:

- Provided to a member living in a licensed* residential home with three to five members
- Focus is on relearning functional daily living skills and behavior management
- Addresses cognitive, medical, physical, behavioral, and psychosocial challenges

*Licensed by the Iowa Department of Inspection and Appeals

Intermittent CNRS:

- Provided to members living in their own homes
- Supports members and their families and caregivers
- Focus is on relearning and managing strategies related to functional daily living skills and behavior management
- Addresses cognitive, medical, physical, behavioral, and psychosocial challenges

Person-centered practices

Person-centered practices

Person-centered language:

- Recognizes the impact of language on thoughts and actions.
- Ensures language does not diminish the uniqueness and intrinsic value of individuals and allows a full range of thoughts, feelings, and experiences to be communicated.
- Emphasizes the importance of cultural preferences and communication style when training direct-support professionals.

Person-centered planning:

- A process in which the needs and preferences of the person receiving the services are described by that person (in collaboration with family, friends, and other circle-of-support individuals) to develop a support plan that ensures they receive the covered services needed in the manner they prefer.
- Enables the person receiving services to make informed choices about their services and who will provide them.
- Is conducted to reflect what is important **to** the individual while balancing what is important **for** the individual, so the delivery of services is in a manner reflecting personal preferences and ensuring health and welfare.

Person-centered practices (cont.)

The purpose of person-centered planning is:

- To emphasize the strengths of the individual.
- To assist a person in gaining control over the life of their choosing.
- To increase opportunities for participation in the community to achieve a full community life.
- To recognize individual desires, interests, and goals.
- To develop a plan that turns an individual's goals into reality.

Successful person-centered planning:

- Has a clear and shared appreciation of the skills, strengths, and capabilities of the person supported.
- Meets regularly with the person and their key supports to review methods used or to brainstorm different approaches.
- Makes meaningful connections in the local community.
- Uses the provided person-centered planning tools and creates an individualized path to success.
- Supports the person and their key supports to continue to be motivated to keep moving forward on their journey. Once the initial goals are met, make new ones that support what is important to and for them, as well as their full community life.
- Is an open process that continues throughout the individual's lifetime.

The person-centered support planning process

The person-centered support planning process:

- Is member-driven.
- Is developed by the community-based case manager (CBCM) in collaboration with the interdisciplinary team (IDT) chosen by members.
- Is completed before services begin and annually thereafter.
- Identifies member's desires and goals.
- Provides direction on service provision regarding the amount, duration, and scope of services, or if self-directed, the services funded.
- Ensures the member and IDT is aware of the contents of the plan each time changes are made.
- Identifies the type of provider for each service.

Provider plans may be more detailed and specific regarding how services are provided.

Additional documents may be needed based on the services chosen.

The provider's role

You are an important member of the individual's support team.

When accepting referrals for HCBS, the provider must review the documentation provided in the referral and determine capacity to meet the person's specific needs. The provider must:

- Ensure qualified and trained staff are available and properly matched with the individual needing supports.
- Assess capacity to meet the person's transportation needs (if applicable).
- Review cultural preferences and communication needs.
- Participate in meet-and-greets with the person.
- Participate and contribute to the person-centered planning process.
- Attest to and return the PCSP after receiving it to acknowledge they are ready to begin services.
- Accept the service referral and initiate services in a timely manner.
- Use the PCSP to develop an implementation plan.
- Ensure direct support professionals are trained on the unique support needs of the participant, use, care and maintenance of any adaptive or assistive devices of equipment, behavioral support plan, risk mitigation plan, the PCSP and service implementation plan (if applicable).

Core components of case management

- Match members to the right community-based case manager based on experience, knowledge, and skills.
- Use person-centered planning through partnership and collaboration with members, natural supports and member-identified interdisciplinary teams to holistically address the member's medical, behavioral, social and educational needs while maximizing health, well-being and independence.
- Coordinate and collaborate across member systems of care to align resources based on need, integrate services, reduce duplication of efforts, and improve continuity of care in a cost-efficient way.
- Continuously deliver, monitor, and assess interventions to meet the member's goals identified in their person-centered support plan.
- Use technology and innovation to improve member outcomes.
- Facilitate continuous improvement programs to address issues and/or concerns to better serve members.

HCBS Settings Rule

HCBS Settings Rule requirements: *HCBS Settings Rule 42 CFR 441.301*

The rule supports enhanced quality in HCBS programs and adds protections for individuals receiving services. The final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for HCBS. In addition, this rule reflects CMS's intent to ensure individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and can receive services in the most integrated setting:

- Wellpoint is responsible for ensuring all contracted providers remain compliant with requirements on an ongoing basis.
- Wellpoint ensures the member receives HCBS in settings fully integrated in the community, supporting full access to the community at large. This includes:
  - Opportunities to seek employment and work in competitive and integrated settings.
  - Engagement in community life.
  - Controlling personal resources.
  - Receiving services in the community to the same degree as those individuals who do not receive HCBS.
- Wellpoint does not contract with any provider who is not compliant with the *HCBS Settings Rule* requirement.

HCBS Settings Rule requirements (cont.)

At a minimum, recredentialing/recertification of providers includes:

- Verification of continued licensure and/or certification (as applicable).
- Compliance with policies and procedures identified during credentialing/certification such as:
  - Background checks and training requirements.
  - Reportable event management.
  - Use of the electronic visit verification (EVV) system.
- Monitoring compliance with the *Settings Rule*.
- Annual HCBS visits that include evaluating the physical location, policies, procedures, and other written documentation, employee training, and employee files (as appropriate).

The *HCBS Settings Rule*, along with additional guidance and fact sheet is available on the CMS Home and Community-Based Services website.

Critical incident reporting

Major (critical) incidents

A major incident is an occurrence involving a member enrolled in a HCBS waiver, Targeted Case Management or Habilitation services that results in:

- Physical injury to or by the member requiring a physician's treatment or hospital admission.
- Death of the member.
- Emergency mental health treatment for the member (EMS, crisis response, ER visit, hospitalization).
- Medical treatment for the member (EMS, ER visit, hospitalization).
- Intervention of law enforcement, including contacts, arrests and incarcerations.
- Report of child abuse or dependent adult abuse.
- A prescription medication error or pattern of medication errors that leads to bullets the six bullet points above.
- A member's provider staff who are assigned protective oversight, being unable to locate the member.
- A member leaving the program against court orders, or professional advice.
- The use of physical or chemical restraint or seclusion of the member.

Reporting major (critical) incidents

When a major incident occurs, or when a staff member is made aware of the event, by the end of the next business day:

- The staff member shall notify the following:
  - The staff member's supervisor.
  - The member and the member's legal guardian, as applicable.
  - The member's case manager or integrated health home (IHH).

- The staff member shall report the incident to Iowa Medicaid by completing the direct data entry form in IMPA and include:
  - The member's name.
  - Date, time, and location incident occurred or was discovered.
  - The names of all staff members and others who were present or responded:
    - To maintain confidentiality of other members, initials must be used.
  - The action taken by the staff to manage the incident.
  - The type of incident as defined in *441 IAC Chapter 77*.
  - Submit additional information within five business days if initial report is incomplete.
  - Completed report shall be maintained in the provider's centralized file with a notation in the member's file.

Case manager or integrated health home will complete required follow-up as prompted by tasks in IMPA:

- Findings and resolution shall be reported in IMPA system within 30 calendar days of the initial report.

Minor incidents

A minor incident is an occurrence that:

- Involves a member enrolled in HCBS waiver services.
- Does not meet the criteria for a major incident.
- Results in the application of first aid.
- Results in bruising.
- Results in seizure activity.
- Results in injury to self, to others, or property.
- Constitutes a prescription medication error.

Process for reporting a minor incident:

- Report when an incident occurs or when the staff is aware.
- Submit completed incident report to supervisor.
- Submit within 72 hours of the incident.
- Maintain in provider centralized file.
- Make a notation in the member's file.

Long-term care facilities

Nursing facility (NF) and intermediate care facility for intellectual disabilities (ICF/ID)

All long-term care facilities must:

- Be approved by Iowa Health and Human Services (HHS).
- Be licensed by the Iowa Department of Inspections and Appeals (DIAL).
- Operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes.
- Comply with accepted professional standards and principles that apply to professionals providing services in a facility.
- Meet applicable provisions of other regulations of the U.S. Department of Health and Human Services.
- Inform residents of their rights and all rules governing resident conduct and responsibilities.
- Be able to meet the needs of the member.

Preadmission Screening and Resident Review (PASRR) process:

Level I screening:

- Prior to admission, all members must complete this screening to determine if they potentially have a mental illness or intellectual disability.

Level II screening:

- This screening is to ensure the facility is appropriate to meet the member's needs if they have been identified as potentially having a mental illness or intellectual disability.

Services provided by long-term care facilities:

- Care coordination and planning
- Physician services
- Nursing services
- Dietary services
- Pharmacy services
- Social services and activities
- Specialized rehabilitation services
- Laboratory services
- Radiology and other diagnostic services
- Dental, vision, and hearing services
- Transportation to medical appointments within 30 miles of the facility

Precertification (prior authorization) for facility services

- Precertification is required for members residing in a NF, SNF, or ICF/ID when:
- ICF/ID — member exceeds the allowable 30 nights of visitation per year.
- SNF — upon admission or at least 72 hours prior to a scheduled admission.
- NF — transportation for needed medical service exceeds 30 miles one way.

Long-term care facilities and Iowa Health and Wellness Plan (IHAWP) members

NF services are a Medicaid state plan benefit and available to qualifying members who have full Medicaid benefits, with two exceptions:

- Iowa Health and Wellness Plan (IHAWP) members who have **medically exempt** status
- Members on MAGI Medicaid coverage groups

To qualify for NF services, the member must reside in a SNF, NF, hospital providing swing bed care, or must be receiving hospice benefits while residing in a SNF or NF:

- Members on IHAWP must have the medically exempt status:
  - Once approved for medically exempt (ME), the member's benefit plan will update to a custodial care benefit plan.
- Members must meet the level of care (LOC) requirements.

To determine if the LOC is met, providers must submit the LOC documentation to Iowa Medicaid.

Informational Letter 2318-MC-FFS SNF & NF Services for IHAWP and MAGI Members https://secureapp.dhs.state.ia.us/IMPA/Information/ViewDocument.aspx?viewdocument=582d72ae-2272-444d-a427-3b6f41fa3827

Long-term care facilities and Iowa Health and Wellness Plan (IHAWP) members (cont.)

In addition, the state's Pre-Admission Screening and Resident Review (PASRR) process must be followed.

To determine if transfer of assets is required, the Iowa Medicaid income maintenance worker will send a request for information to the member:

- If it is not returned, the NF stay will not be covered, except for the allowed 120 skilled level of care days.
- If an IHAWP member's needs are beyond the allowed 120 days, an application must be made to Iowa Medicaid for medically exempt determination.

Informational Letter 2318-MC-FFS SNF & NF Services for IHAWP and MAGI Members https://secureapp.dhs.state.ia.us/IMPA/Information/ViewDocument.aspx?viewdocument=582d72ae-2272-444d-a427-3b6f41fa3827

Change of Ownership (CHOW)

Effective April 30, 2024, Iowa Medicaid has requested a Change of Ownership (CHOW) notice to be submitted at least 60 days prior to the change. Please refer to Informational Letter 2579-MC-FFS Change of Ownership (CHOW):

- The CHOW notice must also be submitted to the Managed Care Organizations (MCOs) and/or the Prepaid Ambulatory Health Plan (PAHPs).
- The CHOW notice must include, at minimum, the following:
  - Provider/facility name
  - Service address
  - NPI
  - TIN
  - Anticipated sell date
  - Buyer's contact information

CHOW (cont.)

The buyer is responsible for submitting the enrollment application and supplemental forms to Iowa Medicaid:

- 470-0254: *Iowa Medicaid Universal Provider Enrollment Application*
- 470-2965: *Iowa Medicaid Provider Agreement General Terms*
- 470-4202: *Electronic Fund Transfer Authorization*
- 470-5112: *Iowa Medicaid Designated Contact Person*
- 470-5186: *Iowa Medicaid Ownership and Control Disclosure*
- W-9: *Request for Taxpayer Identification Number and Certification*

Additional important information:

- The buyer must also register the facility with the Iowa Secretary of State under the Buyer's Information.
- The enrollment process with Iowa Medicaid will not begin until all required documents have been received.
- Applicable to NF and ICF/ID only
- Iowa Medicaid requires a copy of the *Final Purchase Agreement* and *Operational Transfer Agreement* as soon as they are available:
  - The Agreement must include which party will assume liability to Iowa Medicaid if a current debt exists, or if one becomes known to Iowa Medicaid within the statutory lookback period.

The enrollment will not be completed and approved until the Agreements have been received.

LTSS Provider Relations team

We are here to support you

The cornerstone of Wellpoint's provider promise is to empower providers through education and training to serve the needs of our members by delivering a superior provider network experience with:

- A dedicated local team with diverse backgrounds to provide well-rounded provider support.
- A focus on the Wellpoint and provider relationship, provider development opportunities, identification of areas of expansion, and support of provider growth.
- Key positions to ensure on-demand expertise to the issues most important to LTSS providers.

Provider relations team

Provider relationship management representative:

- Ensures providers receive comprehensive training and education on key requirements.
- Engages with other managed care entities to align on training and processes to reduce provider effort.
- Provides one-on-one technical assistance and LTSS subject matter experts.
- Assists providers' compliance with the *HCBS Settings Rules*.
- Provides onboarding training through site visits, tools, and resources.

Workforce development manager:

- Develops and maintain workforce development plan through provider collaboration.
- Serves as a liaison with State partners, MCEs, and providers to implement statewide workforce development (WFD) initiatives and activities.

LTSS Workforce Development

Workforce Development (WFD) — What is it?

- A diverse, stable, and well-trained workforce is crucial to providing quality person-centered services and supports.
- Investment in direct service workers (DSWs) is essential to serving more individuals in their homes and communities.
- DSWs include:
  - Certified nursing assistants (CNAs)
  - Home health aides
  - Direct support professionals (DSPs)
  - Personal care aides
  - Other non-licensed personnel

LTSS Workforce Development Support

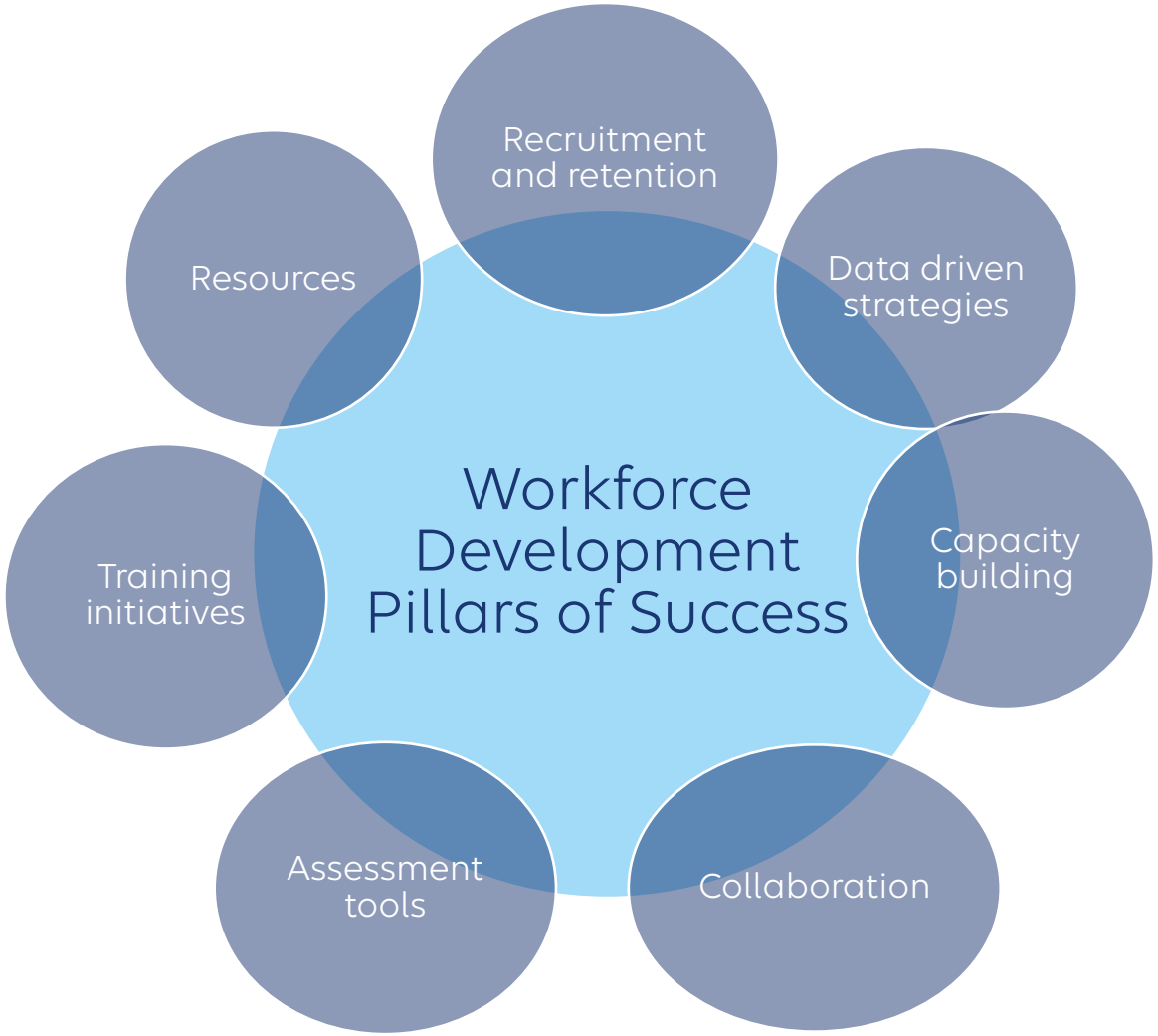
Wellpoint recognizes that HCBS workforce development is crucial to ensure a sufficient supply of qualified workers to provide essential home and community-based services to individuals with disabilities and older adults.

The LTSS Provider Relations team offers workforce development support, ensuring a qualified, competent, and sufficient workforce is established to consistently deliver needed services in a timely manner. Through direct work with providers, we support providers with:

- Capacity-building expansion opportunities.
- Technical assistance.
- Staff recruitment, retention, and development.
- Network enhancement.

Any provider interested in workforce development support can contact our Workforce Development Manager at IALTSSWorkforce@wellpoint.com

LTSS Workforce Development



LTSS Workforce Development Pillars of Success

Recruitment and retention: pipeline development, equity and diversification of the workforce, family caregivers/self-direction to ensure a qualified, competent, and sufficient workforce

Data driven strategies: data collection, monitoring, and evaluation including occupation classification, data monitoring, quality measurement. collects, analyzes, and reports data regarding the provider workforce

Training initiatives: El Sevier Learning Management System: College of Direct Supports, College of Frontline Supervisor Management/Leadership; provider leadership training and support needs to support business model and excellent quality of member service care

Collaboration: WFD offers support with provider recruiting/staffing plan development, and technical assistance for WFD needs.

Assessment tools: WFD will continually assess service initiation needs throughout the state and identify opportunities to maximize provider capacity and expansion. WFD will also support providers in assessing staffing availability based on service needs and building provider recruiting plan.

Capacity building: support providers in building capacity and expanding opportunities through the identification of service needs and meeting member service needs in a timely manner

Resources: WFD webinars, newsletters, state and national information and news regarding WFD updates and climate, office hours, community recruiting events, provider community engagement, and networking opportunities

Quality in LTSS service provision

Iowa LTSS quality management

There are multiple elements used to measure, monitor, and improve quality of LTSS service provision, such as, but not limited to:

- NCQA distinction standards
- Iowa HHS HCBS and CNRS Provider Quality Self-Assessment(s)
- HEDIS® measures
- Care plan audits and service plan reporting
- Member surveys
- Complaints — provider, member, state
- Critical incidents/unusual occurrences
- Member and provider incentives
- Electronic Visit Verification (EVV)
- Case management
- Referral management tracking
- Utilization management data

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

HHS has developed several trainings related to the LTSS quality improvement:

- HCBS Standards and Quality Oversight Reviews — HCBS Standards on slide 13; CNRS Standards on slide 14
- HHS LTSS Continuous Quality Improvement Program Training — How to establish a QI program

Provider responsibilities

Providers are responsible to comply with state and federal laws and requirements

Core set of policies and procedures based on the services enrolled to provide:

- Compliance with state and federal laws for:
  - Intake
  - Admission
  - Service coordination
  - Discharge
  - Referral
- Compliance with laws and regulations
- Guidance and training employees:
  - Identification of processes to ensure services are provided by qualified individuals
  - Completion of child abuse, dependent adult abuse, and criminal background checks pursuant Iowa Code
  - Screening potential employees and entities for federal program exclusion status

Long-Term Services and Supports (LTSS) provider responsibilities

- Provide all HCBS services in integrated settings.
- Complete the Provider Quality Self-Assessment annually.
- All facility-based providers and home health agencies must notify a Wellpoint case manager within 24 hours when a member dies, leaves the facility, moves to a new residence, or moves outside the service area or state.
- Participate in the member's interdisciplinary care team (ICT), dependent upon the member's needs and preference.
- Follow all federal rules and regulations as applicable.
- Provide regular updates related to the care of service delivered.
- Participate in discharge planning.
- Use EVV system as required for personal care services and home health services.
- Verify the member is eligible for services prior to service provision.
- Maintain all licenses, certifications, permits, accreditations, or prerequisites required by Wellpoint and federal, state, and local laws for providing medical services.
- Be an enrolled and approved provider in good standing with Iowa Health and Human Services.
- Document service provision as required by state and federal rules.

Provider roles and responsibilities for all providers

- Primary care providers must provide preventative health screenings.
- Providers must not discriminate against members with mental, developmental, and physical disabilities and must comply with ADA standards.
- Providers must notify Wellpoint of changes such as billing address and name
- Providers must understand and educate members about advanced directives.
- Providers must comply with *HIPAA* requirements and recordkeeping standards.
- Providers must recommend preventive care services to all members
- Providers must identify behavioral health needs.
- Providers must document and bill accurately to avoid fraud, waste, and abuse.
- Providers must provide wheelchair accessibility.
- Providers must have appointment availability and after-hours access.

Cultural competency

We are dedicated to provide quality, effective, and compassionate care to all patients.

We value whole health, a person-centered approach that integrates physical, social, pharmacy, and behavioral health needs to proactively address the wide-ranging factors that contribute to equitable health outcomes:

- We offer translation and interpreter services, cultural competency tips and training, and guides and resources based on the Culturally and Linguistically Appropriate Service (CLAS) Standards.
- Cultural competency and patient engagement is a training resource to increase cultural and disability competency and helps effectively support the health and healthcare needs of your diverse patients.
- Caring for Diverse Populations Toolkit is a resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.
- My Diverse Patients offers resources, information, and techniques to help provide individualized care regardless of their diverse backgrounds, including free CME credits. https://mydiversepatients.com
- Iowa's Health Equity Whole Health Council has introduced a new training series on the social drivers of health: food security, housing, interpersonal violence, and transportation, including an introduction found on the provider website on the Elsevier platform.

Provider revalidation through Iowa Health and Human Services

All providers complete enrollment renewal with HHS every five years.

The provider enrollment revalidation date is based on the date the provider agreement was signed.

After the initial revalidation is completed, the next revalidation date is based on the date the last revalidation was completed.

All providers, **except individual CDAC providers**, complete the revalidation electronically through the Iowa Medicaid Provider Agreement (IMPA) system.

Providers must complete the following tasks in IMPA:

- Review and agree to the new provider agreement
- Verify professional and institutional components of the provider organization and structure
- Complete the *Ownership and Control Disclosure* (OCD)
- Provide individual social security number(s) where indicated

Revalidation for individual Consumer-Directed Attendant Care (CDAC) providers

To stay active with Iowa Medicaid, revalidation is required.

Providers who fail to complete revalidation may have their Medicaid provider number terminated, and claims will no longer be paid.

To revalidate a provider agreement with Iowa Medicaid, Individual CDAC disclosure forms must be signed:

- *Provider Agreement*: 470-2965 Iowa Medicaid Provider Agreement General Terms
- *Disclosure Form*: 470-4612 Individual Consumer-Directed Attendant (CDAC) Disclosure

Return forms to:
Provider Enrollment — Renewal
P.O. Box 36450
Des Moines, IA 50315

Or scan and email to: IMEProviderEnrollment@dhs.state.ia.us

Provider enrollment

Enrolling as an HCBS agency provider with Iowa Medicaid

Providers wishing to provide LTSS services-must complete and submit the following documents to Iowa Medicaid Provider Enrollment Unit by either fax, mail, or email:

For Agencies and businesses applying for HCBS Waiver services, must complete the following forms:

- 470-2917 *Iowa Medicaid Universal HCBS Waiver Provider Application*
- 470-4202 *Iowa Medicaid Electronic Funds Transfer Authorization Form* (with voided check)
- 470-2965 *Iowa Medicaid Provider Agreement General Term*
- 470-5112 *Iowa Medicaid* Designated Contact Person
- 470-4457 *Atypical Provider Declaration* (if provider does not have an NPI)
- IRS *Form W-9*

Adding a waiver service to an already enrolled and active provider, complete sections I and III of form 470-2917 *Medicaid HCBS Waiver Provider Application*.

Iowa Medicaid screens the application. If an HCBS application was submitted, additional review is required:

- If additional information is requested but not received from the provider within 120 days, the application is cancelled.

If the application for **a new provider** is enrolled but not yet active, the provider needs to log in to IMPA and enter in required information:

- Once active, the provider receives a welcome letter within 10 business days.

Enrolling as an HCBS individual Consumer-Directed Attendant Care with Iowa Medicaid:

Individual Consumer-Directed Attendant Care (CDAC) provider applicants must complete and submit the following forms to Iowa Medicaid:

- 470-2917 *Iowa Medicaid Universal HCBS Waiver Provider Application* (Sections: I and II)
- 470-2965 *Iowa Medicaid Provider Agreement General Term*
- 470-4202 *Iowa Medicaid Electronic Funds Transfer Authorization Form* (with voided check)
- 470-4612 *Individual CDAC Disclosure*
- 470-4457 *Atypical Provider Declaration*
- 470-4227 *Request & Acknowledgement to Conduct Registry & Record Check*
- Proof of age (copy of driver's license, birth certificate, state issued ID, passport)
- IRS *Form W9*

Iowa Medicaid screens the application. If an HCBS application was submitted, additional review is required:

- If additional information is requested but not received from the provider within 120 days, the application is cancelled.

If the application for **a new provider** is enrolled but not yet active, the provider needs to log in to IMPA and enter in required information:

- Once active, the provider receives a welcome letter within 10 business days.

Enrolling as nursing facility (NF) or intermediate care facility for intellectually disabled (ICF/ID) with Iowa Medicaid

To enroll with Iowa Medicaid, all nursing and ICF/ID facility providers must meet the following requirements:

- Is licensed by the Iowa Department of Inspections, Appeals and Licensing (DIAL) Health Facilities Division
- Approved by Iowa Medicaid to provide services
- Abides by the provisions identified within the provider agreement with Iowa Medicaid

The following forms are required for submission to Iowa Medicaid:

- *470-2917 Iowa Medicaid Universal HCBS Waiver Provider Application (Sections: I and II)*
- *470-2965 Iowa Medicaid Provider Agreement General Term*
- *470-4202 Iowa Medicaid Electronic Funds Transfer Authorization Form (with voided check)*
- *IRS Form W9*

Application and credentialing

Providers must submit an application and complete the credentialing process with the MCO. This process is separate from the Iowa Medicaid application process.

Credentialing is the process of validating the professional competency and conduct of providers and health delivery organizations. They must meet rigorous credentialing standards to be part of the Wellpoint provider network. The credentialing process involves verifying licensure, board certification, and education.

- Recredentialing is required every three years to stay current with professional information.

Wellpoint credentials the following health delivery organizations (HDOs):

- Home health agencies
- Skilled nursing facilities (nursing homes)
- Behavioral health facilities providing mental health and/or substance abuse use disorder in an inpatient, residential, or ambulatory setting
- Adult family care/foster care homes

Member management tools for providers

Availity Essentials

Availity Essentials offers secure access to manage daily transactions with payers.

Availity Essentials does not require special software and is accessible with high-speed internet, using Google Chrome/Microsoft Edge/Firefox browsers.

Availity Essentials features:

- **Electronic transactions** provide a secure platform where providers can perform eligibility and benefit inquiries, check claim status, and track remittance.
- **Multi-payer platform** ensures a consistent workflow for all participating health plans, allowing providers the same user experience.
  - Through this multi-payer portal, providers can access several of WellPoint's Care Central applications, the one-stop shop for LTSS providers.

Availity Essentials can be found at https://Availity.com.

Contact Availity Essentials directly at **800-AVAILITY (800-282-4548)**.

Availity Essentials — getting started

To initiate registration, navigate to Availity Essentials Registration at the top right corner of the screen and select "New to Availity? Get Started."
Providers must first register with Availity Essentials, specific to the option that best describes the situation:

- **A healthcare provider** is a provider who is part of a physician's practice, a mental health provider, or a non-physician provider. These providers typically have an NPI and are also known as medical providers.
- **Caregiver or atypical provider** includes HCBS waiver program providers. This provider type is often referred to as *atypical* or *non-medical* providers.

Need help with registration? Explore this training site to review a registration process recording and access additional resources. training site.

Want to learn more about Availity? Explore the Digital Solutions Learning Hub to review comprehensive training materials and access additional resources. learning hub.

Availity Essentials – getting started (cont.)

- All organization types — Only the person who will be designated as the administrator needs to register.
- The following information is needed:
  - Physical and billing addresses
  - Tax ID (EIN or SSN)
  - NPI (if you have one)
  - Primary specialty/taxonomy
- **Atypical providers** — Some provider types are not required to have an NPI. If you are an atypical provider, in the **Organization Setup** step, look for this verbiage and the associated button: **This organization does NOT have an NPI. This organization is an atypical provider and does not provide healthcare, as defined in *45 Code of Federal Regulations (CFR) section 160.103*.**

Availity Essentials – getting started (cont.)

Once the Availity Essentials registration form is complete and sent, the submitter will receive an application ID used for tracking the status of registration:

- Keep this ID in a safe place if you need to follow up on the status of your registration.
- Visit the **Manage my Organization** page to check the status of the registration:
  - **Approved —** You are ready to submit transactions on Availity Essentials.
  - **Pending —** You are not quite ready to submit transactions. Be sure to stay updated on your application by visiting the **Manage My Organization** page and follow-up on any actions needed.
  - **Rejected —** Review the **Organization Activity** section to review the notes on why the application was rejected and next steps. Registrations might get rejected when the organization with duplicate information already exists on Availity Essentials.

Availity Essentials – getting started (cont.)

Once the organization's administrator has registered and verified their identify, the administrator can:

- **Add users —** Add users one at a time, use a spreadsheet to upload multiple users at once, and copy a user from one organization to another.
- **Explore roles and permissions —** Assign roles to users in the organization based on each user's job function.
- **Assign a backup Administrator** to help manage users and roles.
- **Enroll for additional features.**
- **Add additional tax IDs** to the business details, as applicable.

Once all registered and ready to get started, *Availity's Reference Guide for Users and Reference Guide for Administrators* is available through the Availity Notification Center.

Availity Essentials — additional resources

Several other tools and resources are available in the Payer Spaces section in the Availity Essentials platform:

- Clear Claim Connection: Research procedure code edits and receive edit rationale.
- Custom Learning Center: Find job aids, reference guides, and educational videos.
- Education and Reference Center: Locate important policies, forms, and educational resources.
- Remittance Inquiry: View, print, or save a remittance advice from the past 24 months.
- Patient360: Access a member's health and treatment history, including care reminders and gaps in care.
- Provider Online Reporting: Generate custom reports, including member rosters.

Billing and reimbursement

Reimbursement requirements

An authorization does not guarantee payment:

- The member must be eligible for the service at the time services were provided.
- Facility Long-Term care stays exceeding the allowed leave of absence (LOA) days must be prior authorized.
- Appropriate HCBS waiver services must be authorized through the person-centered planning process.

Reimbursement has some basic requirements:

- Claims must be submitted electronically and on the correct claim form.
  - CMS-1500 is used for HCBS services
  - CMS-1450 (UB-04) is used for long-term care facility stays, with the appropriate revenue code.
- Claims must be submitted with the correct code and modifier combination, if applicable.
- The claim must be submitted with the provider's NPI or atypical provider ID number.
- Dates of service on a claim form cannot span multiple months:
  - A new claim form must be used for services provided in a different calendar month.
- Claims are subject to Coordination of Benefits (COB) if the member has other health insurance coverage.

Providers must accept reimbursement based upon established rate methodology:

- Providers cannot request additional payment from the member (balance billing).

Services must be medically necessary

Iowa Administrative Code (IAC) specifies services must be deemed medically necessary and meet the following criteria:

- Be consistent with the diagnosis and treatment of condition
- Be in accordance with standards of good medical practice
- Be required to meet the medical need of the patient and be for reasons other than the convenience of the member or their practitioner or caregiver
- Be the least costly type of service which would reasonably meet the medical need of the member
- Be eligible for federal financial participation unless specifically covered by state law or rule
- Be within the scope of the licensure of the provider
- Be provided with full knowledge and consent of the member or someone acting on their behalf unless otherwise required by law or court order in emergency situations
- Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use billing procedures and documentation requirements described in 441 — Chapters 78 and 80 of the *IAC*.

Electronic payment enrollment

Wellpoint is contracted with Enrollsafe as our Electronic Fund Transfer (EFT) vendor.

Information on how to get started with Enrollsafe can be found at https://provider.amerigroup.com/docs/gpp/IA_CAID_PU_EFTEnrollment.pdf

Log in to the Enrollsafe enrollment hub at enrollsafe.payeehub.org.

For Enrollsafe support related to registration and enrollment, contact:

- **877-882-0384** from 8:00 a.m. to 7:00 p.m. CT.
- Email support@payeehub.org.

Electronic remittance advice (ERA) is available through Availity Essentials or your clearinghouse or billing service.

Providers must receive one payment from Wellpoint before they can enroll in Enrollsafe.

What is client participation (member liability)?

- A monthly dollar amount the member is required to contribute towards the cost of waiver services
- Determined by Iowa Health and Human Services (HHS)
- HHS notifies the member and Wellpoint the amount of the monthly client participation amount.
- Providers must collect the client participation amount from the member.
- Providers bill gross, or full, charges to Wellpoint:
  - Wellpoint will deduct the client participation amount by the monthly client participation amount, if it has not been met.
- If the sum of a third-party payment and a member's client participation equals or exceeds the reimbursement amount established for services, Wellpoint will make no payment to the provider.
- Personal Needs Allowance (PNA) for members in long-term care facilities accounts for money a member is allowed to keep, deducted from the member's monthly income before calculating their client participation.
  - This allowance can be used for personal items like clothes, snacks, haircuts, etc.

Claims overview

The Claims Overview section on the provider website offers information and guidance on many topics. Some of the common topics used by LTSS providers are:

- Claim submission: required information for facility and professional providers.
- Claims timely filing.
- Corrected claims.
- Documentation standards.
- Duplicate services on same date of service.
- Eligible billed charges.
- Proof of timely filing.
- Reimbursement for maximum units per day.
- Sanctioned and opt-out providers.
- Scope of practice.

Claim payment disputes

A claim payment may be disputed due to any of the following, after a claim has been *finalized*:

- Contractual payment issues
- Disagreement over reduced or zero-paid claims
- Post-service authorization issues
- Other health insurance denial issues
- Claim code-editing issues
- Retro-eligibility issues
- Claim data issues
- Timely filing issues

Claim-related issues *not* considered claim payment dispute:

- Claim inquiry – question about a claim but not a request to change the claim payment
- Claim correspondence — when Wellpoint requests further information to finalize a claim:
  - May include medical records, itemized bills or other information about other insurance
- Medical necessity appeals — a pre-service appeal for a denied service:
  - For these, a claim has not yet been submitted.

Claim payment dispute process

The payment dispute process consists of two internal steps:

1. **Claim payment reconsideration**:
    - First step in the provider payment dispute process
    - Initial request for an investigation into outcome of the claim
    - Most issues are resolved at this step.
2. **Claim payment appeal**
    - Second step in the provider payment dispute process
    - If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.

For more information on the claim payment dispute process, please refer to the appropriate section of the provider manual.

Corrected claims

- We will accept corrected claims up to 365 days from the date of the Explanation of Payment (EOP) or date of last adjudication.
- The maximum timeline is two years from the date of service.
- Any corrections submitted from this timeline would be denied, not rejected, for failure to meet timely filing.

Additional claim resources

- Provider Update - Explanation of Payment (EOP) Education
- Provider Update - Interim billing reminders- facility claims
- Provider Update - Corrected Claims
- Provider Update- Claims Submission Guidance- Date Spanning - Y88 Denial
- Wellpoint - Medicaid Claims Timely Filing
- Wellpoint Claims & Billing Manual
- Wellpoint systems configuration:
  - Go to the provider website at provider.wellpoint.com/ia.
  - Select **Claims Overview** under *Claims* tab.
  - Select the **System Configuration** updates under Claims Resources. Configurations are updated every Friday.

Electronic Visit Verification (EVV)

What is EVV?

EVV is a technological solution used to electronically verify that personal care providers and home health providers delivered or rendered services as billed.

Why was it implemented?

The *21st Century Cures Act* requires states to implement EVV for all Medicaid personal care services (PCS) and home health care services (HHCS) requiring an in-home visit by a provider.

Ensures financial accountability:

- Reduction in unauthorized services
- Improvement in quality of services to individuals
- Reduction in fraud, waste, and abuse

EVV in Iowa

EVV systems must verify:

- The type of service performed.
- Individual receiving the service.
- Date of service.
- Location of service delivery.
- Individual providing the service.
- Time the service begins and ends.

Iowa implemented EVV through a managed care choice implementation model with CareBridge:

- EVV for PCS was implemented on January 1, 2021.
- EVV for HHCS was implemented on January 1, 2024.
- All service codes requiring EVV may be found here: Iowa EVV Codes

CareBridge and EVV

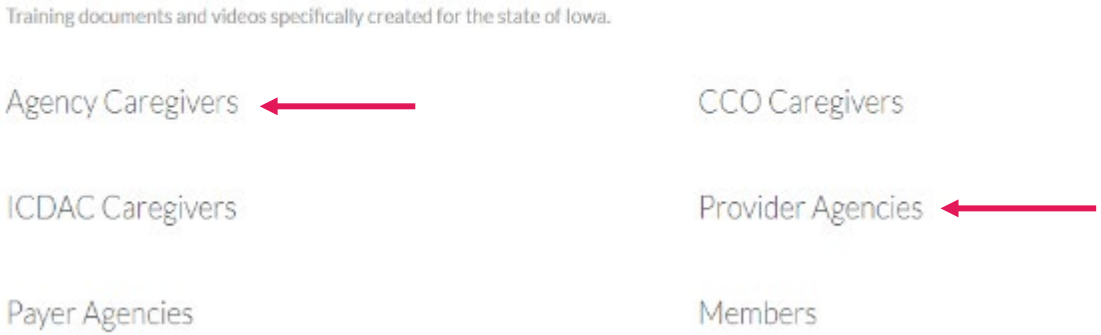
Providers must register with CareBridge EVV Solution and complete the following milestones:

- Complete the *EVV Provider Setup and Access Request Form*: http://survey.carebridgehealth.com/iaevv.
- Log into the CareBridge portal.
- Acknowledge an Authorization/Schedule an Appointment.
- Complete an EVV visit using CareBridge EVV.
- Submit a claim via CareBridge EVV.

Providers can register for CareBridge EVV User Training following the Provider Agency Training:

- This training covers the information necessary to complete the milestones.
- Use the Roadmap to EVV Success to ensure successful implementation.

To access the Iowa-specific Provider Portal and Caregiver Instructor training and documents, select the **Provider Agency** and **Agency Caregivers** on the CareBridge website.



Using the CareBridge EVV platform

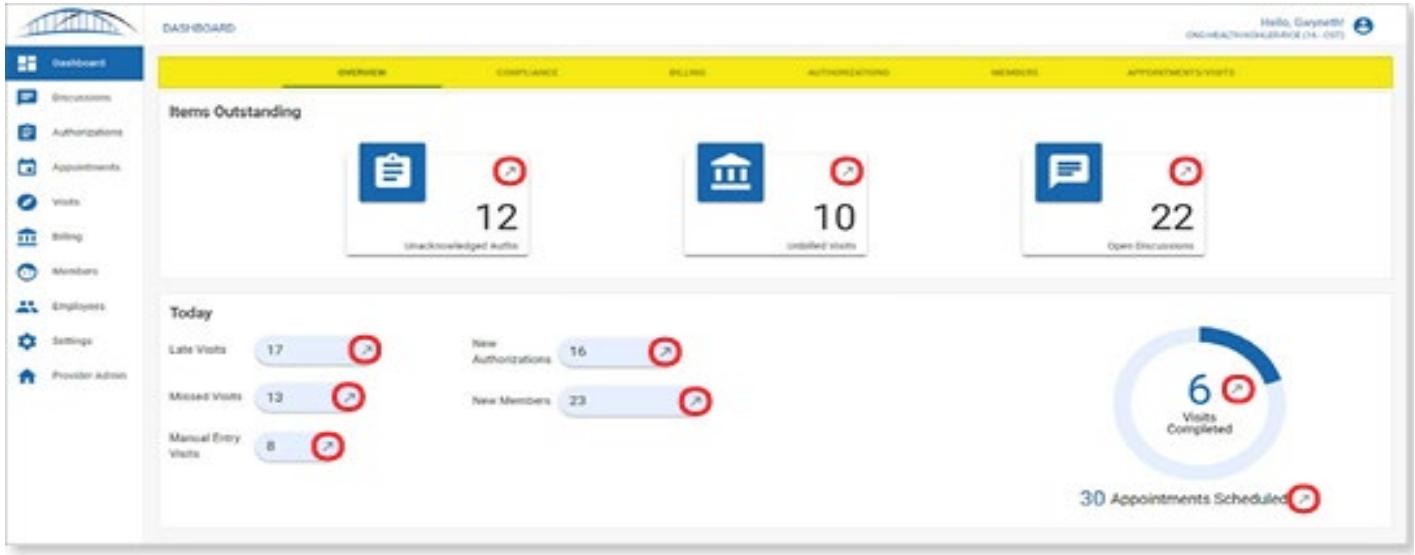
Training resources within CareBridge provide guidance with the following:

- Understanding the dashboard
- Complete agency and employee setup
- EVV workflows
- Scheduling appointments
- Billing
- Reporting

Providers can call or email CareBridge EVV technical support (for example, product functionality, scheduling, checking-in/checking-out):

- CareBridge Support Center hours are Monday to Friday 8 a.m. to 5 p.m. CT.
- Phone: **844-343-3653**
- Email: IAEVV@carebridgehealth.com

Using the CareBridge EVV platform (cont.)



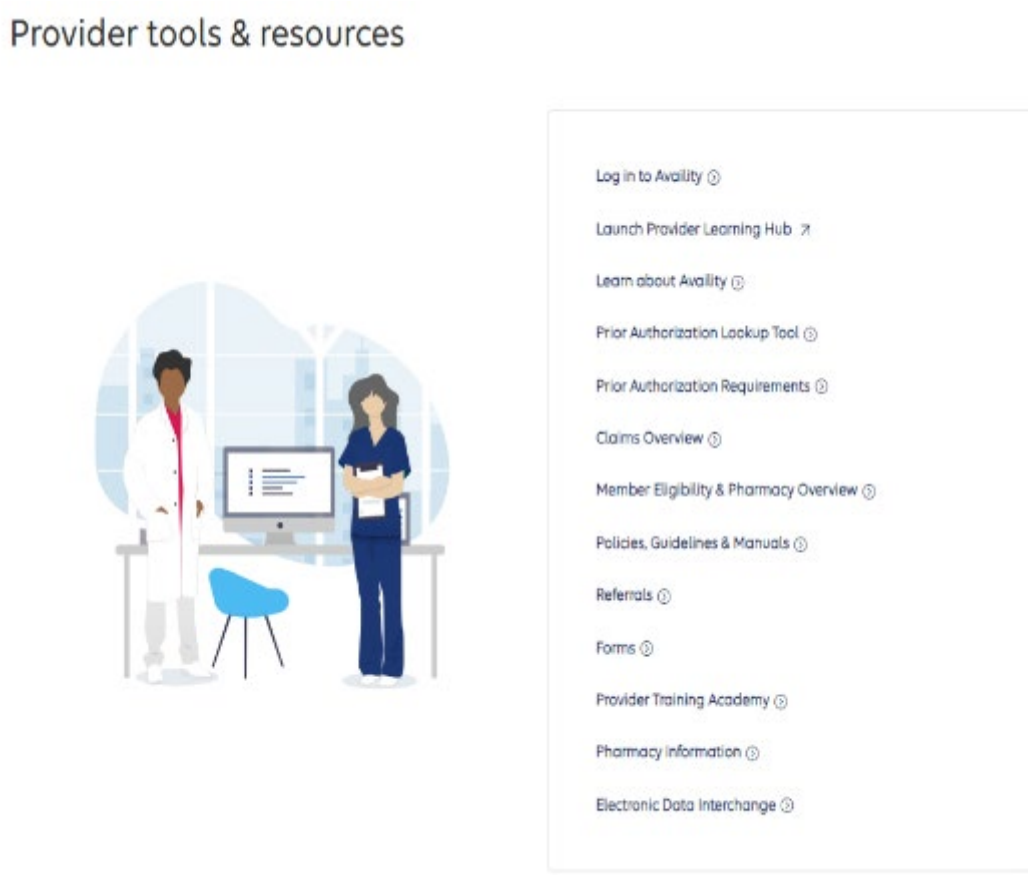
- **OVERVIEW:** This dashboard displays metrics related to items that are outstanding or may require action and metrics related to operational efficiency within the Provider Agency today.
- **COMPLIANCE:** This dashboard displays metrics to better understand how many completed visits are EVV-compliant and how many are the sources of non-compliance.
- **BILLING:** This dashboard displays metrics related to the revenue cycle of completed visits in the CareBridge Solution.
- **AUTHORIZATIONS:** This dashboard helps Agency Employees better understand the number of active authorizations and authorizations by service type.
- **MEMBERS:** This dashboard helps Agency Employees explore the number of active members.
- **APPOINTMENTS & VISITS:** This dashboard displays metrics related to the number of scheduled appointments and completed visits.

Provider resources

Provider website

The provider website provider.wellpoint.com/ia has information related to topics below and much more:

- Key contacts and maps for the LTSS provider experience team, provider account managers for non-HCBS services, HCBS regional manager for case management assignments
- Provider manuals for both Medicaid and Medicare programs administered by Wellpoint
- Provider communications
- System configuration updates
- Training resources
- Resources for Availity Essentials
- Information on claims



Provider manual materials

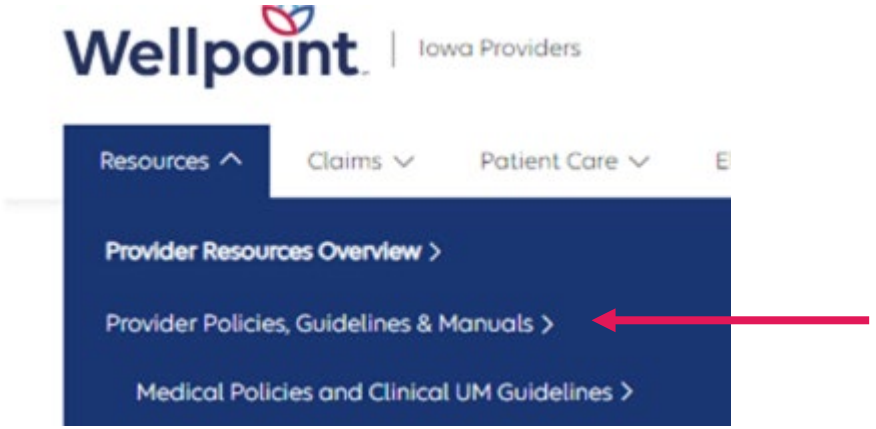
Our provider manuals outline key information about our case management and UM programs, quality standards for provider participation, claims and appeal guidance, prior authorization requirements, and much more.

[Medicaid provider manual]

[Medicaid 2023 Provider Digital Engagement Supplement]

[Wellpoint Medicare Provider Manual]

[Medicare 2023 Provider Digital Engagement Supplement]



Resources and training

Information, training and resources on a variety of topics can be found on the provider website.

Key training and resource information include:

- Provider orientation, supplemental learning and guides
- Serving diverse populations
- Cultural competency
- Social drivers of health (SDOH)
- Provider Pathways — a 24/7 educational resource that offers a foundation for providers:
  - On the provider website, select **Training Academy** under *Resources,* and then select **Provider Pathways** under *Training Resources*.
  - Psych Hub — training contractor for behavioral health providers offering self-paced courses in evidenced-based interventions
  - Offerings include podcasts, videos and other accredited content with opportunities for free continuing education units.
  - SBIRT — Screening, brief intervention, and referral to treatment
  - Online provider toolkit to assist with early intervention, identification of risk behaviors, and referrals related to substance abuse

Provider resources and information

Resource/topic	Description	Link
Iowa Health & Human Services (Iowa HHS) Provider Services webpage	Landing page for IHHS Provider Services which has various information and links for information enrolling as a provider, training, claims and billing, and a host of other information.	https://hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services
IHHS Provider Reference Guide	Guide that provides a one-stop resource for general information about Medicaid and providing Medicaid services in Iowa.	hhs.iowa.gov/media/7812/download?inline
HCBS training slides	HHS HCBS waiver training	https://www.ltss-iowa-trualta.com
HCBS *Provider Quality Self-Assessment*	Required annually for HCBS providers	hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/provider-trainings
Medicaid LTSS Program Comparison Chart		IDHS Medicaid LTSS Program Comparison Chart
Iowa HHS Home- and-Community Based Services (HCBS) provider manual.	Details eligibility, provider, and service requirements for all seven of the Iowa Medicaid waiver programs.	Medicaid Provider Policy Manuals | Health & Human Services (iowa.gov) Home and Community-Based Services (HCBS) Waivers Program | Health & Human Services (iowa.gov)
Iowa HHS HCBS Habilitation Provider Manual	Details key information regarding general program policies, member eligibility, provider-specific policies, and billing guidance.	Habilitation Provider Manual
Iowa Medicaid Portal Access (IMPA) landing page		IMPA
Wellpoint provider website	Wellpoint Iowa provider website	provider.wellpoint.com/ia
Email address for providers to directly submit questions or call Wellpoint Provider Solutions.		ProviderSolutionsIA@Wellpoint.com Provider Solutions phone: **800-454-3730**
Email address for individual CDAC providers	Submit questions, concerns, and requests. This email address is monitored by LTSS provider experience team members.	CDACintake@wellpoint.com
CareBridge Training Guide	CareBridge provider website, EVV	CareBridge Training Guide

Thank you for being part of our provider network

provider.wellpoint.com/ia

Coverage provided by Wellpoint Iowa, Inc.

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