HCBS Employment Summit
October 19, 2017

An Overview of Medicaid Funded Employment Services (Refer to attached PowerPoint)
LeAnn Moskowitz

HCBS Intellectual Disability & Brain Injury Waivers & State Plan HCBS Habilitation

The IME still pays for Prevocational Services (hourly rate vs. daily rate) and added a new pre-voc activity of career exploration.

Pre-Vocational Services and Career Exploration activities are about learning & work experiences—learning non-job- task-specific skills and strengths, also called general employability skills. Services support individuals to engage in activities that lead to participation in individual employment. Career exploration can happen in groups of 2-4, while some activities are 1:1. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

The goal of anyone participating in pre-vocational is that they want a job in the community or to be self-employed.

Supported Employment Services—Individual, Small Group, Long Term Job Coaching (LTJC)

Every single person's plan is going to look different and their path will look different.

Supported Employment services are provided to those individuals who need support because of their disabilities, and who are unlikely to maintain or move ahead without those long-term job supports and is based on the member's needs. You want to promote retention and encourage fading over time. But again, everyone's path and/or plan will look different.

The expected outcome of these services is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals.

We are working on pulling data for employment outcomes and looking where are now in 2016 and 2017 vs. our baseline of 2013 data—now these are preliminary numbers, but we are seeing less in pre-voc and more in SE, but an increase in day habilitation. We are still massaging and cleaning up the data, and will be sure to share it will you once we do.

Prevocational & Supported Employment Services Matrix- (See attached)

Along left-hand side is the service code, unit, along with the FFS floor rate (some providers have a different rate)

Chapter 83 service plan requirements lays out documentation requirements for services.

And now added the **staff qualification and training requirements**–not reflected in current rule—this is what we honor right now and this is what your HCBS specialist would be looking for. These will be added and formalized in rule and will be coming in a rule package for chapter 77 re-vamp, that will also include updates to critical incident reporting and settings clarification.

Link to IME's HCBS FAQ's & E1st Guidebook Link Find Midpage : https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers) We will also make the matrix available there as well.

What is also new to the matrix is HCBS Employment Service Authorizations section. We wanted to know what is hard and fast vs. where do MCO partners have the opportunity to create their own processes and structures. Added contacts for IME or MCOs if you have 1. Questions about HCBS Services in General 2. Questions about specific member's services 3. Questions about claims.

MCO Panel

Panelists:

Jeff Lund, UnitedHealthcare

Marissa Eyanson, AmeriHealth Caritas

Denise Juhl, Marsha Kreho, David Klinkenborg, Donna Wendt

Let's begin with Walking through the ***Service Authorization Process*** as that is where a lot of questions come in-

Please refer to Employment Service Matrix & Section on HCBS Employment Service Authorization

United Healthcare:

HAB Members: UnitedHealthcare does not require prior authorization for HCBS services. All supports are derived from the IDT.

ID and BI Members: Supports and Services derived from IDT meeting. CBCM is responsible for entering the service requests and for uploading the current person-centered plan. For all BI and ID individuals –all their employment services are pre-approved.

The IDT meets to complete the assessment and plan/treatment plan, which is written by the CBCM/IHH. Part of our internal processes that might cause a fork in road, is related to those who have a hab funding source. None of the actual support services are pre-approved, but will be approved if appropriately reflected in the assessment and plan.

BI or ID waiver—CMs are responsible for submitting requests for pre-approval and then reviewed by team lead (and in some situations the request is forwarded to Jeff as well).

Amerigroup:

Prior service authorization is required for HCBS services. Service authorization process requires or makes the IHH/CBCM responsible for submitting the service request with the person-centered plan to Amerigroup for review. This can be done via fax or through the provider portal.

AmeriHealth:

Prior authorization is required for HCBS services. The IDT gets together and generates a plan that the CBCM or IHH submits service authorization request. The utilization manager reviews for accuracy and alignment with the assessment & plan, then either approves or not. The IHH Care Coordinator or CBCM is responsible for entering the service requests and for uploading the current person-centered plan into Jiva.

Fee for Service (FFS):

CM or IHH builds the service plan into ISIS –enters a service span for the service plan –if they want a service that requires a pre-approval that will kick off a milestone in the system—medical services reviewer will ask for that information required like the certificate of medical necessity for pre-voc and SE (can take 24 hours to 7 days for that initial authorization). If it is an emergent need or urgent review (status page), it can be turned around in 3 days –get a milestone back and NOD and send to provider. Sometimes you need a speedy review, let's say someone is offered a job on Thursday to start Monday. This is an example of an emergent need.

Service Re-Authorization

Amerigroup:

The IHH CC or CBCM is responsible for submitting a service request with the person-centered plan to Amerigroup for review.

AmeriHealth:

The team will have gathered, developed a plan, then the IHH or CBCN submits. The IHH Care Coordinator or CBCM is responsible for entering the service requests into Jiva. Continued authorization of a high-intensity service or of multiple services that result in high intensity may require additional information to justify the level of service provided or monitor the effectiveness of the services.

United:

For Hab members, as long as it is listed in their treatment plan, it won't need to be re-approve. It is not required to have prior authorization for Prevocational and Supported Employment services.

For ID/BI members, the CBCM submits the request or the Supports and Services derived from IDT meeting. CBCM is responsible for reauthorizing the service requests and for uploading an addendum to the current person-centered plan if necessary.

FFS:

Works the same as the initial authorization and typically, the service plan runs for 12 months so the authorization typically spans 12 months. If requests are denied, this is typically due to there not being a goal to work on or doesn't seem to align with the assessment. The IHH Care Coordinator or Community Based Case Manager is responsible for entering the service spans in the program request in ISIS. IME Medical Services approves the service plan. Once the service plan has been approved the IHH is responsible for sending the NODs to the HCBS provider.

Service Changes

Amerigroup:

If the service provider or member request changes, contact the CBCM/IHH, to request the changes. The CBCM or IHH then submits the request and there has to be an amendment to the plan.

AmeriHealth:

Process looks the same for us. If the HCBS service provider or member requests changes they contact the IHH CC or CBCM to have that discussion and request the changes. New request(s) are then submitted via our Jiva system.

United:

For Hab members, if the HCBS service provider or member requests changes they contact the IHH CC. The IHH CC is responsible for submitting, via fax or email, the requested changes including the amended person-centered plan. ID and BI Members: If the HCBS service provider or member requests changes they contact the CBCM to request the changes. The CBCM is responsible for authorizing the changes in the supports and services and issuing an addendum to the person-centered plan.

FFS:

The IDT will have had a conversation and identify new or additional supports needed and this will be documented into plan and CM will update the plan and service span and update in system. Same process as for initial and re-authorization, going before the medical reviewer. If the changes occur in the current month, CM can change it that month and can place a comment in the comment box and medical reviewer will sign off. If it was something that occurred in the past, you must contact the information desk to make those changes as the CM can only make changes for the current or future months in ISIS.

***What* is the Utilization Management process or medical review process for your MCO?**

Amerigroup:

The Behavioral Health Utilization Management department reviews service requests. UM staff may contact the IHH CC or CBCM if additional information is needed, for example, scope of services or frequency of mental health symptoms.

AmeriHealth:

The LTSS UM department reviews and approves or denies the service requests. UM staff may contact IHH/CBCM staff if there are questions about the amount, duration, and scope of services requested or to propose alternatives if denial is anticipated. If something doesn't line up with the assessment and/or service plan, they will contact the CBCM/IHH and may contact the provider to help make the request.

United:

For Hab members, the UHC Alert team completes claim reviews to identify triggers regarding utilization of services. ID and BI Members: The CBCM authorizes the services and supports and only in specific instances are they reviewed for appropriateness.

On the IHH side there are more steps that are taken behind the scenes and first questions will go there between utilization management and IHH, and then to provider. Same is true for the ID/BI side. They want to make sure services authorized are reflected as the goals and needs in the plan and assessment.

FFS:

Falls under the certificate for medical necessity is what is required for SE/prevocational services, and we fashioned these documents so that medical reviewers have what they need when they are completed correctly and thoroughly to determine if the service is medically necessary and appropriate.

What is the background of utilization management staff at the respective plans, and what training and on-going support are they provided around supported employment services (understanding these services)?

Amerigroup UM clinical reviewers are Nurses, Social Workers, or LMHC's. All are licensed and have provided direct service in behavioral health or related case management services.

LTSS UM for Amerihealth are staff with experience in working for IME/medical services, providers, case managers. They are directed to look at the whole picture and purposely hired staff that represented an array of experiences.

United's utilization staff are typically RNs, former providers, and case managers.

<u>Communication to HCBS Providers</u>

FFS:

The IHH CC and CBCM is responsible for providing the comprehensive service plan and providing a notice of decision for the provider for services authorized. IHH or CM are the main link—we communicate a lot through our informational letters.

United:

IHH will be communicated from the coordinators NOD comes directly from IHH. UHC will communicate to the IHH approvals for level of care (LOC) determination via email. For IHH plan the grid within the plan is the authorization or NOD. For ID/BI will receive notice via CBCM.

AmeriHealth:

The IHH CC or CBCM is responsible for providing the comprehensive service plan. Providers access the Service Plan, which includes current approved services, or the service authorizations for their agency through the Provider Portal. Also please subscribe to our network news as these are the sort of things that are the 'front burner' for our provider networks at the moment.

Amerigroup:

The IHH CC or the CBCM is responsible for providing the comprehensive service plan to the service provider. Service providers may access eligibility and service authorizations through the provider portal / Patient360.

Question: What is the expectation of the CM related to processing (changes in) authorizations—had occasions with weeks passing without communication or response?

AmeriHealth's response is that is not the expectation. If you are having requests and communications that are not being responded and attended to, you should then go to the manager/up the chain. You can continue to up if you are not getting responses from or continue to run into difficulty with your case manager and/or their supervisor, folks like provider services and your account executive.

Amerigroup also has Provider services and you can contact them at 1-800-456-3730.

Question: Is there a timeline for the service plan to be out to the providers—when can we expect to get those?

United: you should have it back completed within a week and/or by the start of the plan year.

Amerigroup: we also try to within 7 days.

Question: Utilization Management—in terms of real utilization—you will have lots of data to determine –is there a place where we can use the outcome data –we won't have access to the aggregated data. How will we use or learn from what you are learning (from the data we are all collecting and now sharing with our MCO partners)?

MCOs are asking for a lot of data and employment will be one of them—we will be collecting these (IME) and we will be processing and sharing with everyone in a public forward-facing way. We will share the employment performance data measures here later in the meeting.

Another good tool to see trends is the DHS Iowa Health Link Page (see below)—there are links to the aggregate monthly MCO data and reports and quarterly data and reports—lots of great information in there on critical health points we are looking at and see if it's useful to you. The IME is willing to hear about other important data points to be monitoring.

DHS/Iowa Health Link Performance Data- https://dhs.iowa.gov/ime/about/performance-data

Also refer to attached presentation titled 'An Overview of Medicaid HCBS Employment Performance Measures' & 'Performance Measures Copy of FINAL (MCO) AccQual E-10'

Data is the what and a less of the why—would help to have the why.

Question: Issue we are seeing as a provider is that service authorization is taking too long—takes too long between request and funding authorization –often we are waiting on the CBCMs to come and have the IDT meeting or get what the individual needs—we have to find a way to make this happen.

United's response is that we are teaching our CBCMs—if some ISE is left, some of this can be used to fund initial job coaching and they have also been made aware that this needs to flow faster and in some cases, assignment to JC tiers can be figured out before the job even occurs. Contact Jeff directly if you continue to run into these issues.

Additional CRP Example- We could see that the service was approved within 2 days via the provider portal/system, but were told or made to wait 10 days until the service could be provided.

AmeriHealth:

We can address that at the individual provider level and with case specific examples. We do have an emergent process and it does respond in 3 days.

Amerigroup:

We have an escalation process for emergent requests. An emergent request is a request for services that will impact a member's wellbeing if not addressed emergently. Lateness of request is not an emergent request and will need to be processed normally. They can contact us directly and we can do addendum to the treatment plan and review either same day or next day—they have to have an addendum in order to request the emergent need—they can do that over the phone and document it.

Question: What words can we use with the CBCMs—we can gather urgently, we can do an addendum and can do by phone?

AmeriHealth's response is to tell them that they will lose the job. We do have to have the 'prescription' in place and call the case manager. They got to understand that how important it is and that the job will be lost.

Amerigroup also reminds that you communicate to the CBCM or IHH if there will be transportation needs or changes because of a job offer or change as we look at the whole person and want to make sure all the needs are being met and that something is not missed. Over communicate with the IHH and CBCM and you can say we need to make a quick pivot here.

Question: We had an issue where the CBCM had not met with individuals, came to the work site, had to produce these people or threatened to cut off services the next day. (This was a quarterly face-to-face visit and not set up with the individual members) Can the case manager do that?

Amerigroup's response is that is a personnel issue and need to speak with a manager. This needs to be addressed on the individual level with the case manager and their supervisor. Quarterly meetings should be planful and prepared meetings, and coordinated with the member, this is the expectation. Instance like the above, please share with us and provide the member number and scenario, we want to know and we want to address these concerns.

Question: Can the MCO/utilization management reduce the LTJC tier level without an IDT? Also, already expecting an end date for that level of support, though we are just starting and we don't know yet. We are seeing decreasing without our knowledge, as don't know until we are looking in the system.

United:

Not aware of this happening as it should not be happening without your knowledge. Initial approval for a job tier is for 3 months (knowing that people often need more support initially) and as we near the end of the first month, we will reach out to you to see how it is going and what tier you think the person will be using. Most of the time it will be a tier 4 or 5 that will be initially approved, but we can stop at the end of the first month if we need to readjust based on what we learn from the provider.

AmeriHealth:

It sounds like a Utilization management process in which they do *an approval other than as requested*—meaning the service or the intensity of the service is different than what was requested by the IDT. It's not a change. You have the right to appeal. This usually happens because there is an issue of information submitted doesn't match the request. Sometimes if you feel like information was missing, you can ask them to look at it again, the CBCM/UM, saying here is more information vs. if they think it is a mismatch.

If an appeal doesn't result in what the member/provider is needing/requesting, the next step is a state fair hearing after the appeal—you have continuation of benefits (as requested) –and you have to request that the continuation of benefits. We automatically approve that in these situations. Again you do have to request that continuity of benefit and within certain time frames. Management of care is something different and we have to learn to navigate this different system.

Comment: Fine print-says the client will pay for the services should they be declined or not approved, this then leaves the member at risk.

Question: Our Regional director from the MCO is saying – for example a member is at a tier 4 LTJC but goes into the hospital or can't make it to work, and we don't hit those tier 4 hours. Originally, we were told by the MCO that we could bill at a lower tier, now they are saying we cannot.

United:

If you set a tier 4 and then something happens that month that is outside your control-like someone is sick or shifts are reduced- then we would ask that you submit the bill for the tier approved and then the next month would be that expected to return to that level of support. If it turns into a regular thing or new normal, then we would want to change the lower tier.

AmeriHealth:

Same for us, short term 'bump in the road' we want you to bill as approved. If it becomes a long-term thing, then we need to adjust. If you run into bounces on this, your best line of sight is your account executive(s).

Amerigroup:

2 Approaches: For Habilitation members, any bump in the road or short term changes, contact your IHH and they can have a direct line with utilization to discuss what needs to happen.

ID/BI- contact CBCM and they can figure out what needs to happen, we want to make sure you are paid and the member gets the services and supports they need.

Question: We have submitted appeals and heard back that the appeal is not accepted or it is declined, what is happening?

AmeriHealth's response is actions are appealable vs. a grievance, an issue has to be appealable. Sometimes if you hear that an appeal was declined, it is possibly because it should have been filed as a grievance. In a general sense, in order to file an appeal there has to be a decision or action that you are appealing. An appealable action is a notice itself or a denial. Reach out directly to appeals department/staff within each of the MCOs to determine why it was not accepted or further denied.

Question: If one tier was approved and step outside of those hours- still bill for that tier they were approved for vs the tier they actually worked? What about when they bump to a higher tier because they are working more hours? As an agency, we are penalized if the person is working more hours, requiring a higher tier, as we have to bill at what was approved and are getting denied when trying to increase the tier due to increase of work hours.

United:

Bill for the approved tier if it is a one off, whether higher or lower.

I would ask if that is sustainable and if yes, then request higher tier—look for forward casting and to build that in as a possibility for those tiers.

Amerigroup:

As a team, do forward casting and build that in a possibility for those tiers. We approve as submitted for the most part and work the CBCM to move things seamlessly and we don't want you to be penalized.

AmeriHealth:

Clarify on mid-month changes, we are defaulting to the higher tier. We rely on CBCM to get that information from the provider on what is happening and changes needed. We will leave the current authorization in place and in the next month we will start a different tier should that be the new need.

Question: To continue to bill at the tier approved-how do you advise the providers document this and it not appear fraudulent (in a retrospective audit)?

FFS:

Let's say there is an authorization for tier 4 and there is a one off and will resume normal working hours upon their return. Your documentation can reflect that the member was hospitalized or whatever was going on, and can also make a notation in the person-centered service plan. If it will be long-term, then the CM is expected to make the change in the plan/system.

We provided a range of hours because we recognize that there will be changes in needs—want it to be flexible and responsive –monitor to see if it will be the new norm.

United:

Same for us. Be sure to make a note and document what you do—make clear it is short-term and/or a one off thing.

Amerigroup:

IHH is the same as FFS. If you do try to bill at a lower tier you will get a kick out. Communicate with the IHH or if you can proactively go in and make the adjustment, do that if member's needs changes.

How do you use the member's core standardized assessment (CSA) and interdisciplinary team (IDT) to inform employment service planning & service authorization?

AmeriHealth:

We rely heavily on IDT and them getting together and letting us know via the case manager what the plan is and what the employment service needs are. The assessment is to match up with and inform the plan and service authorization(s) –helps to weigh out the requested authorizations.

United:

CSA is the foundation for identifying support needs for the individual and start all the planning discussions for the IDT—CBCM's role is to make sure that whatever is written within the plan is reflected in the assessment.

Amerigroup:

The same is true for us. We use the assessment (as well as social history) as the foundation and then work with the member, their family, and their team to develop the service plan/goals and what activities need to occur to achieve those goals.

Can you talk about the process for providers obtaining a copy of the CSA (InterRAI or SIS)?

FFS:

The CM or care coordinator should be providing a copy of the assessment and member can request too from Medical services. Telligen does for IHH-they upload through IMPA and the care coordinator or case manager can go out and fetch that as long as the members is assigned to you in ISIS.

United:

SIS is done in house and would receive copy from CBCM. For IHH, you should receive it directly from them as well.

AmeriHealth:

Receive a copy from your case manager, if you don't receive it, talk with the supervisor.

Amerigroup:

You should also receive from CBCM/IHH and escalate if you don't hear from them or there are breakdowns.

Question: Hard time conceptualizing the InterRAI and operationalizing into the plan—when we do the InterRAI, many of the questions are 'within the last 3 days…" used to determine hab eligibility is how we have been trained to use the InterRAI and then connecting to the person centeredness.

LeAnn's Response: So the CSA is utilized for the HCBS waivers and hab to determine a level of care that would otherwise be met in facility where it not for the waiver services—non financial need is based on mental health diagnosis or symptoms or functional limitations related to CMI—so we are looking for functional limitations that make the need for services necessary—it should be informing the plan – assessment is an informational tool to inform planning and if you go back and look at the rules it says that service determination is by assessment and other supporting documentation so I would encourage you to do that.

Assessment is intended to inform and when I have a PCP and have long-term goals (6-12 months), which are priority needs that show up in my assessment. So what kind of interventions do we need to do as a provider to support the person in their goals –these then inform the provider service plan –maybe a training on PCP and using the tools would be beneficial.

To be financially eligible for habilitation, you must be eligible for Medicaid—if not can't get services through the Hab program.

How is the CSA, plan, and IDT utilized to inform tier assignment and authorization for an individual member for long term job coaching?

United:

Actual tier assignment comes from the IDT—should be a correlation with the assessment scores/higher needs for supports –assessment sets the tone and assignment is result of discussions of the IDT.

AmeriHealth:

Input from the IDT is what we like to look at or see, along with progress notes and feedback from the team on how they think it's going to move. We want to talk about the plan looking forward and how are we looking to fade out.

Amerigroup:

Be sure to fill that out this section in the assessment, often times we will see this crossed out. But ultimately, the it's driven by the IDT

Identified Need: Additional training-how to make the case for the member –need detail and depth

Question: When we are talking about fading from job coaching, follow along indefinitely is a tenant of SE that I am not willing to compromise. We still need to be there for some folks, though we are getting a significant push to fade and/or eventually leave everyone. What makes you think that the member doesn't need that follow along?

LeAnn's Response is that we redesigned the tiers the way we did, specifically tier one, for the follow along in the long-term. We all have a responsibility to raise the bar and build natural supports, but we can remain supportive and attentive to the individual and the employer.

Please describe the process your plan utilizes to monitor and determine service re-authorization and/or services changes related to a member's tier level for long term job coaching?

United:

Reach out to Jeff—LTJC is looked at every 3 months and will be authorized for a short amount of time and then it will extend after. As I said before, we will check in with towards the end of that first month to see if it needs to be adjusted.

AmeriHealth:

Usually we are talking about sufficient information and cascading through to UM, painting the picture for what the support needs are or will be, what it's going to look like and what your support plan is.

Amerigroup:

If it's a re-authorization or change we want to know what is it changing or why are things staying the same? And you support this with documentation—not too little, not too much or the Goldie Locks effect.

Question: Is Long-term job coaching not long-term? If someone has significant challenges, what does that look like? Where does the person's choice weigh into it?

General response: Kickbacks or approval other than requested, typically this has come from utilization and as stated before, there is a misalignment between the assessment/plan and what was requested. Sometimes it is an issue of not having enough or the proper documentation, haven't painted the picture of the need. You can make the case, either through explaining verbally or in writing why the person needs LTJC or the level of LTJC requested. If you are not getting timely or appropriate responses or meeting other barriers, you escalate the matter up the chain of command.

How long should service authorization take within your organization?

United:

Any leftover SE can be used to start up job coaching supports that are needed quickly.

Amerigroup:

You can submit request weeks ahead of time –but a 7 day turnaround is our expectation. IHH having a hard time tracking services that are ending and beginning at different times so whatever you can do to assist the IHH you work with would do well for everyone as they continue to refine their systems. Again, LTSS is 7 days –if you need it right away fax it in.

AmeriHealth:

7 days, or 3 days if it is an emergent need—can request up to 45 days in advance.

Question: Does your plan cover the purchasing AT for work?

United:

In general no, but if it can be billed under durable medical equipment it could be.

Amerigroup:

Same as United and would encourage using other resources like IVRS and Easter Seals.

Under BI waiver, specialized medical equipment funding is available, and is intended to pay for what's not covered under durable medical equipment

VR- have to be eligible for VR services and be working with VR for access to AT resources and funding.

Identified Need: Can you share UM guidelines to guide providers?

Question: What is the status of the sheltered workshops?

HCBS Setting Requirements- must be delivered in community based system –was extended to 2022 but as a state we continue to move forward and have completed onsite reviews for non-residential settings about 86 providers across the state. Developed corrective action plans if issues cited to align with setting requirements. We are not going to stop funding pre-vocational services, but it will look different, though some regions have said they are ending funding for work activity.

Question: CESP requires 12 hours of on-going education, but there is also the requirement for 4 hours of on-going education for Medicaid requirements…are these additional hours?

Medicaid says you need to have the certification to provide individual supported employment services.

You could use your 4 hours of on-going education towards the 12 required hours needed to maintain your CESP.

Question: Coming across Habilitation members being found ineligible, in a way that seems sudden, impacting their employment services…what can we do?

So, we are talking about individuals who are receiving employment services through hab and they are eligible for habilitation because their income is under 150% of federal poverty level. We know that

information gets loaded into the Iowa automated benefits system by an income maintenance worker who may make a keying error. I would contact income maintenance worker and ask for it to be re-evaluated if you think there is a mistake in the calculation of their income.

One thing to think about is for members on MEPD get a sheet with their guidelines, and the federal calculation is different for MEPD. Look up their actual level in IMPA or ELVS—have to think about Medicaid eligibility as this keeps them qualified for Hab. But again, if in doubt, contact income maintenance worker.

If you are worried about earning, be sure to get the person connected to a benefits planner. There is a way to establish their income to maintain their benefits.

Question: Opportunities for people to take the CESP outside of the two testing events offered by APSE?

No, but we are trying to offer more trainings but we only offer the two times to test right now. We are looking at offering more, it's a need based thing. There are other ways to get certified, life ACRE.

Heard once that if you had more than 30 people, you could proctor your own test—will have to follow up with Iowa APSE to learn more about this option. Could potentially do a collaborative effort.

Thank you to everyone!