

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State of Iowa** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

Home and Community Based Services - Intellectual Disabilities (ID) Waiver

C. Waiver Number: IA.0242

Original Base Waiver Number: IA.0242.

D. Amendment Number: IA.0242.R06.01

E. Proposed Effective Date: (mm/dd/yy)

04/01/20

Approved Effective Date: 04/01/20

Approved Effective Date of Waiver being Amended: 07/01/19

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to make the following revisions to Performance Measures:

1. Designate those PMs where data will be consolidated and stratified across all Iowa 1915(c) waivers. Include language to clarify the use of consolidated and stratified data. These changes affect all measures in Appendix D as well as LC-c1.
2. revised language in H-1-a-i to reflect consolidation and stratification of performance measure data.
3. Revise the language of PMs SP-e1, SP-e2, QP-a1 in accordance with direction from CMS through the recent Iowa Brain Injury Waiver renewal.
4. Add 3 new PMs, in accordance with direction from CMS through the recent Iowa Brain Injury Waiver renewal. New measures: QP-a2, QP-b2, and QP-b3.
5. Answered App H-2-a as required for validation.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A Waiver Administration and Operation	
Appendix B Participant Access and Eligibility	LC-C1
Appendix C Participant Services	QP-A1, QP-A2, QP-B2, QP-B3
Appendix D Participant Centered Service Planning and Delivery	All Performance Measures
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	
Appendix H	H-1:a-i, H-2-a
Appendix I Financial Accountability	
Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)**
 - Modify Medicaid eligibility**
 - Add/delete services**
 - Revise service specifications**
 - Revise provider qualifications**
 - Increase/decrease number of participants**
 - Revise cost neutrality demonstration**
 - Add participant-direction of services**
 - Other**
- Specify:

revisions to performance measures
addition of new performance measures
implementation of consolidated and stratified Performance measure reporting

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The State of Iowa requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Home and Community Based Services - Intellectual Disabilities (ID) Waiver

C. Type of Request: amendment

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years 5 years

Original Base Waiver Number: IA.0242

Waiver Number: IA.0242.R06.01

Draft ID: IA.011.06.02

D. Type of Waiver (*select only one*):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/19

Approved Effective Date of Waiver being Amended: 07/01/19

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

1915(b)Iowa High Quality Healthcare Initiative was previously approved on February 24, 2016, with an effective date of April 1, 2016

Specify the §1915(b) authorities under which this program operates (check each that applies):

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Waiver Program Summary

The goal of the Iowa HCBS Intellectual Disability (ID) waiver is to provide community alternatives to institutional services. Through need-based funding of individualized supports, eligible participants may maintain their position within their homes and communities rather than default placement within an institutional setting. The Iowa Department of Human Services (DHS) Iowa Medicaid Enterprise (IME) is the single state agency responsible for the oversight of Medicaid.

Individuals access waiver services by applying to their local DHS office or through the online DHS benefits portal. Each individual applying for waiver services must meet intermediate care facility for individuals with intellectual disabilities (ICF/IID) (as defined in 42 CFR §440.150) level of care. IME's Medical Services Unit (MSU) is responsible for determining the initial level of care assessments for all applicants, and level of care reevaluations for fee-for-service participants. Managed Care Organizations (MCOs) are responsible for conducting level of care reevaluations for their members, with IME having final review and approval authority for all reassessments that indicate a change in the level of care. Further, the MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. In the event there is a waiting list for waiver services at the time of initial application, applicants are advised of the waiting list and that they may choose to receive facility-based services.

If the applicant is deemed eligible, necessary services are determined through a person centered planning process with assistance from an interdisciplinary team. After exploring all available resources, including natural and community supports, the individual will have the option to choose between various traditional and self-directed services.

Services include adult day care, consumer directed attendant care, day habilitation, home and vehicle modification, home health aide, interim medial monitoring and treatment, nursing, personal emergency response, prevocational, respite, supported community living, supported community living-residential based, supported employment, transportation, financial management services and independent support brokerage services, self-directed personal care, individual directed goods and services, and self-directed community and employment supports.

Through increased legislative focus of appropriations, mental health and disability services redesign, and infrastructure development through Iowa's Balancing Incentives Payment Program, it is the goal of Iowa to offer a more uniform and equitable system of community support delivery to individuals qualifying for waiver services.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. *Appendix E is required.*

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*

- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and

welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

Not Applicable

No

Yes

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

Geographic Limitation. A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Limited Implementation of Participant-Direction. A waiver of statewide requirements is requested in order to make participant-direction of services as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in Appendix C are met

for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for

each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

DHS seeks continuous and ongoing public input through a variety of committees and organizations. Specifically, the Mental Health Planning Council meets monthly and provides input as necessary. DHS has appointed one staff person from the IME Long Term Care Unit to the Council, which includes various stakeholders including participants and families, providers, case managers, and other State departments. IME is also invited to attend a number of association and advocacy group meetings (i.e., Iowa Association of Community Providers, Iowa State Association of Counties, Iowa Health Care Association, and Olmstead Task Force) to provide and seek feedback on service planning, cost reporting, quality assurance documentation requirements, and case management issues.

The public has the opportunity to comment on Iowa Administrative rules and rule changes through the public comment process, the Legislative Rules Committee, and the DHS Council. The IME also provides notice of applications, renewals and amendments by including notice in the IME e-News emails and on the IME website.

IME used the following processes to secure public input into the development of the 2019 ID Waiver Renewal:

- 1) IME Website Posting - The public notice and the Waiver renewal was posted to the DHS IME Website under the category, News & Initiatives (<https://dhs.iowa.gov/sites/default/files/2018%20ID%20Waiver%20Renewal%20Application.pdf?012820191944>). The public posting period was December 6, 2018 through January 4, 2019.
- 2) DHS Field Office Posting - IME provides notification to the DHS Field Office, which in turn, notifies each DHS Field Office to post the Waiver Public Notice and to provide a copy of the CMS Waiver renewal for any public request. The public posting period was December 6, 2018 through January 4, 2019.
- 3) IME Public Notice Subscribers - Medicaid members, Medicaid providers, legislators, advocacy organizations and others who wish to remain informed regarding Iowa Medicaid can subscribe to the IME Public Notice webpage. All subscribers will receive electronic notice whenever an update/public notice is posted. The public posting period was December 6, 2018 through January 4, 2019.
- 4) Iowa Tribal Nations Notification - The IME Tribal Nations liaison notified all Nation governments via email on December 6, 2018, of the ID Waiver renewal. The notifications indicated a 60 day comment period. The comment period December 6, 2018 through February 4, 2019. The liaison did not receive any comments or questions during this period.

During the public comment time period and the tribal notification open comment period noted above, no comments were received on the 2019 ID Waiver renewal.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Wines

First Name:

Brian

Title:

Program Manager

Agency:

Iowa Department of Human Services/Iowa Medicaid Enterprise

Address:

100 Army Post Road

Address 2:**City:**

Des Moines

State:

Iowa

Zip:

50315

Phone:

(515) 256-4661

Ext:

TTY

Fax:

(515) 725-1360

E-mail:

bwines@dhs.state.ia.us

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Steenblock

First Name:

Jennifer

Title:

Federal Compliance Officer

Agency:

Iowa Department of Human Services/Iowa Medicaid Enterprise

Address:

100 Army Post Road

Address 2:

Jsteenb@dhs.state.ia.us

City:

Des Moines

State:

Iowa

Zip:

50315

Phone:

(515) 256-4636 Ext: TTY

Fax:

(515) 725-1360

E-mail:

Jsteenb@dhs.state.ia.us

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

Mike Randol

State Medicaid Director or Designee

Submission Date:

Apr 16, 2020

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

Randol

First Name:

Michael

Title:

Medicaid Director

Agency:

Iowa Medicaid Enterprise

Address:

611 5th Avenue

Address 2:

City:

Des Moines

State:

Iowa

Zip:

50309

Phone:

(515) 256-4621 Ext: TTY

Fax:

(515) 725-1630

E-mail:

Attachments

mrandol@dhs.state.ia.us

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

The waiver is operated by the state Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

The Medical Assistance Unit.

Specify the unit name:

Bureau of Long Term Care, Iowa Medicaid Enterprise

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

MCOs are responsible for delivering covered benefits, including physical health, behavioral health and LTSS in a highly coordinated manner. Specific functions include, but are not limited to, the following:

- Developing policies and procedures for ongoing identification of members who may be eligible for waiver services;
- Conducting comprehensive needs assessments, developing service plans, coordinating care, and authorizing and initiating waiver services for all members;
- Conducting level of care reassessments with IME retaining final review and approval authority for any reassessments which indicate a change in the level of care;
- Delivering community-based case management services and monitoring receipt of services;
- Contracting with an entity or entities for financial management services to assist members who elect self-direction (i.e., Iowa's "Consumer Choices Option");
- Maintaining a toll-free telephone hotline for all providers with questions, concerns, or complaints;
- Maintaining a toll-free telephone hotline for all members to address questions, concerns, or complaints;
- Operating a 24/7 toll-free Nurse Call Line which provides nurse triage telephone services for members to receive medical advice from trained medical professionals;
- Creating and distributing member and provider materials (handbooks, directory, forms, policies and procedures, notices, etc.);
- Operating an incident reporting and management system;
- Maintaining a utilization management program;
- Developing programs and participating in activities to enhance the general health and well-being of members; and
- Conducting provider services such as network contracting, credentialing, enrollment and disenrollment, training, and claims processing.

FFS

Those participants who have not made an MCO selection, or who are otherwise ineligible for managed care enrollment as defined in the Iowa High Quality Healthcare Initiative §1915(b) waiver, will continue to receive services through the fee-for-service delivery system. As such, the State will continue to contract with the following entities to perform certain waiver functions.

Member Services (Contractor: Maximus) as part of a contract with IME to disseminate information to Medicaid beneficiaries and provide beneficiary support as part of their customer service contract. Additionally, the Member Services Unit provides clinical review in effort to identify beneficiary population risks such that additional education, program support, and policy revision can mitigate risks to the beneficiary when possible.

Medical Services (Contractor: Telligen) as part of a contract with the IME conducts level of care evaluations and service plan development ad-hoc reviews to ensure that waiver requirements are met. In addition, the IME MSU conducts the necessary activities associated with prior authorization of waiver services, authorization of service plan changes and medical necessity reviews associated with Program Integrity and Provider Cost Audit activities.

Home and Community Based Quality Assurance (Contractor: Telligen) as part of a contract with the IME reviews provider compliance with State and federal requirements, monitors complaints, monitors critical incident reports and technical assistance to ensure that quality services are provided to all Medicaid members.

Program Integrity and Recovery Audit Coordinator (Contractor: Optum) as part of a contract with the IME reviews provider records and claims for instances of Medicaid fraud, waste, and abuse. These components are evaluated and analyzed at an individual and system level through fraud hotline referrals and algorithm development.

Provider Services (Contractor: Maximus) as part of a contract with the IME coordinates provider recruitment and executes the Medicaid Provider Agreement. The Provider Services Unit conducts provider background checks as required, conducts annual provider trainings, supervises the provider assistance call center, and manages the help functions associated with the IME's Individualized Services Information System (ISIS).

Provider Cost Audit (Contractor: Myers and Stouffer) as part of a contract with the IME determines service rates and payment amounts. The Provider Cost Audit Unit performs financial reviews of projected rates, reconciled cost reports, and performs onsite fiscal reviews of targeted provider groups.

Revenue Collections Unit (Contractor: HMS), as part of a contract with the IME, performs recovery of identified

overpayments related to program integrity efforts, cost report reconciliations, third-party liability, and trusts.

Pharmacy (Gould Health Systems), as part of the contract with IME, this unit oversees the operation of the Preferred Drug List (PDL) and Prior Authorization (PA) for prescription drugs. The development and updating of the PDL allows the Medicaid program to optimize the funds spent for prescription drugs. The Pharmacy Medical group performs drug Prior Authorization with medical professionals who evaluate each request for the use of a number of drugs.

Point-of-Sale (POS) (Contractor: Gould Health Systems), as part of the contract with the IME, this is the pharmacy point of sale system. It is a real-time system for pharmacies to submit prescription drug claims for Iowa Medicaid beneficiaries and receive a timely determination regarding payment.

All contracted entities including the Medicaid Department conduct training and technical assistance concerning their particular area of expertise concerning waiver requirements. Please note that ultimately it is the Medicaid agency that has overall responsibility for all of the functions while some of the functions are performed by contracting agencies. In regards to training, technical assistance, recruitment and disseminating information, this is done by both the Medicaid agency and contracted agencies throughout regular day-to-day business.

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in

conducting waiver operational and administrative functions:

The Iowa Department of Human Services, Iowa Medicaid Enterprise policy staff, is responsible for oversight of the contacting entities. The DHS IME is the state agency responsible for conducting the operational and administrative functions of the Intellectual Disability Waiver.

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

IME is an endeavor that unites The Department of Human Services (DHS) State Staff and "Best of Breed" contractors into a performance-based model for the administration of the Iowa Medicaid program. The IME is a collection of specific units, each having an area of expertise, and all working together to accomplish the goals of the Medicaid program. Housed in a single building, the IME has contract staff who participates in the following activities: provider services, member services, provider audit and rate setting, processing payments and claims, medical services, pharmacy, program integrity, and revenue collections. All contracts are selected through a competitive request for proposal (RFP) process. Contract RFPs are issued every five years.

All contracted entities are assigned a State-employed contract manager, are assessed through their performance-based contracts, and are required to present their performance on contract standards at a monthly meeting to the Medicaid Policy Staff. Monthly meetings are designed to facilitate communication among the various business units within the IME to ensure coordination of operations and performance outcomes. Further, non-MCO contracted entities and Medicaid Policy staff are located at the same site, which limits the barriers of routine management and oversight. In addition, all contracted agencies are required to complete a comprehensive quarterly report on their performance to include programmatic and quality measures designed to measure the contract activities as well as trends identified within Medicaid programs and populations.

The State has established a MCO Oversight and Supports Bureau within IME to provide comprehensive program oversight and compliance. Specifically, a Bureau Chief, reporting directly to the Medicaid Director, will be responsible for directing the activities of three MCO account managers, two quality improvement outcome oversight staff, one encounter data specialist, one actuarial rate setting specialist, and three MCO member/provider analysts. Each MCO account manager will be paired with an MCO member/provider analyst to oversee contract compliance for one designated MCO. The MCO account managers will serve as liaisons between the MCOs and the State, and will be the point of contact coordinating communications and connecting subject matter experts. The MCO Bureau will work directly with the IME Program Integrity Unit, which oversees compliance of all IME providers, including the MCOs. In addition to the MCO Bureau, the IME has added two additional contract oversight staff for managed care related vendors, a business analyst, a data analyst, a communications specialist, and an additional program integrity specialist.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		

Function	Medicaid Agency	Contracted Entity
Waiver expenditures managed against approved levels		
Level of care evaluation		
Review of Participant service plans		
Prior authorization of waiver services		
Utilization management		
Qualified provider enrollment		
Execution of Medicaid provider agreements		
Establishment of a statewide rate methodology		
Rules, policies, procedures and information development governing the waiver program		
Quality assurance and quality improvement activities		

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

AA-2: The IME shall measure the number and percent of months in a calendar quarter that each MCO reported all HCBS PM data measures. Numerator = # of months each MCO entered all required HCBS PM data; Denominator = # of reportable HCBS PM months in a calendar quarter.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MCO performance monitoring

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="MCOs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

AA-1: IME shall measure the number and percent of required MCO HCBS PM quarterly reports that are submitted timely. Numerator = # of HCBS PM quarterly reports submitted timely; Denominator = # of MCO HCBS PM quarterly reports due in a calendar quarter.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MCO performance monitoring

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="MCOs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 90%; height: 30px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 30px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Through the Bureau of Managed Care each MCO is assigned state staff as the contract manager; and other state staff are assigned to aggregate and analyze MCO data. This staff oversees the quality and timeliness of monthly reporting requirements. Whenever data is late or missing the issues are immediately addressed by each MCO account manager to the respective MCO.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

If the contract manager, or policy staff as a whole, discovers and documents a repeated deficiency in performance of the MCO, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of payment compensation.

General methods for problem correction include revisions to state contract terms based on lessons learned.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="Contracted Entity and MCOs"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged	<input type="checkbox"/>	<input type="checkbox"/>	
		Disabled (Physical)	<input type="checkbox"/>	<input type="checkbox"/>	
		Disabled (Other)	<input type="checkbox"/>	<input type="checkbox"/>	
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	
		HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
		Medically Fragile	<input type="checkbox"/>	<input type="checkbox"/>	

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability	0		
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

Per 441 Iowa Administrative Code 83.60(249A), a participant must have “a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person’s condition was during the developmental period and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.”

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is (*select one*)

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is (select one):

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	14203
Year 2	14345
Year 3	14488
Year 4	14633
Year 5	14780

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of

participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

The state does not limit the number of participants that it serves at any point in time during a waiver year.

The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	12912
Year 2	13041
Year 3	13172
Year 4	13303
Year 5	13436

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
Residential Based Supported Community Living	
ICF/ID (including MFP) transition	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup)*:

Residential Based Supported Community Living

Purpose *(describe)*:

Within the ID waiver program, services may be provided to children outside of the parental home. This service is called the Residential Based Supported Community Living (RBSCL). RBSCL services are provided in licensed Residential Care Facilities for Children with Intellectual Disabilities (RCF/ID) that are licensed by the Iowa Department of Inspections and Appeals. The 72 RBSCL slots are separate from the 125 reserved capacity slots for members living in ICF/IDs, nursing facilities, transitioning from the MFP grant, and out-of-state placements. The RBSCL program is designed for children under the age of 18 that receive services outside of the family home in a licensed RCF/ID.

Describe how the amount of reserved capacity was determined:

Seventy-two (72) slots have been reserved for use in the RBSCL program based on fiscal analysis and services needs. RBSCL reserved capacity slots are for use by new entrants into the ID Waiver program.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	72
Year 2	72
Year 3	72
Year 4	72
Year 5	72

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (provide a title or short description to use for lookup):

ICF/ID (including MFP) transition

Purpose (describe):

The state reserves 125 slots each year for use by participants living in an ICF/ID, nursing facility or out of state placement who choose to access services in the ID Waiver program. A reserved capacity slot is also available to members accessing the Money Follows the Person (MFP) grant as they transition from MFP funding to the ID waiver after one year of MFP funding. Slots are available for use by any eligible person for the ID waiver program that currently resides in an ICF/ID, nursing facility or out of state placement has lived there for at least six months, and chooses the ID waiver program over institutional services.

Once the reserved capacity slot is accessed by a participant leaving an institution, the slot is not available to anyone else during the current waiver year. The ICF/ID reserved capacity slot will revert back into the pool of available ICF/ID reserved capacity slots at the end of the ID waiver year, ending June 30 each year. This will assure that no more than 125 slots are used in any given year and will assure that 125 slots are available annually. Once the participant gets on the ID waiver, they are included in the annual participant count towards the total numbers served and unduplicated participant count identified in Appendix B-3 sections a. & b.

Describe how the amount of reserved capacity was determined:

The 125 slots are based on anticipated movement of consumers moving from an ICF/ID, nursing facility or out of state placement to community based settings. During the next five years, it is anticipated that the additional slots will be needed to accommodate members moving to the community from ICF's/ID and nursing facilities due to the Money Follows the Person (MFP) grant. The MFP grant is scheduled to end December 31, 2019, barring any additional federal funding for the program. The state is developing a sustainability plan to support and assist members to move from facilities to the ID Waiver after the MFP grant funding ends.

The MFP grant allows members living within an ICF/ID to move to community based services funded through the ID waiver. It is anticipated that during the last year of the MFP grant that 75 participants will move from ICF's/MR or nursing facilities to the ID waiver program. The MFP grant funds the first 365 days of services provided in the community. After the first year, the participant will apply for and receive a funding slot to the ID waiver. The reserved capacity slots are intended to assure that participants living in ICF's/ID or nursing facilities have a funding slot available to make the transition to the community and continued funding through the ID waiver program after MFP funding ends. As part of the MFP grant, the IME will develop a sustainability plan to assure that members choosing to leave an ICF/ID, nursing facility or out of state placement are have the support needed to access community supports through the ID Waiver program after the MFP funding ends December 31, 2019.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	125
Year 2	125
Year 3	125
Year 4	125
Year 5	125

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Per Iowa Code 441-83.61(4), if no waiver slot is available, DHS enters applicants on the ID waiver waiting list and DHS assesses applicants that submit a HCBS Priority Needs Assessment to determine the applicant's priority need.

Emergency need criteria are as follows:

- The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.
- The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.
- The applicant is living in a homeless shelter and no alternative housing options are available.
- There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.
- The applicant cannot meet basic health and safety needs without immediate supports.

Urgent need criteria are as follows:

- The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.
- The caregiver will be unable to continue to provide care within the next 60 days.
- The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.
- The applicant is living in temporary housing and plans to move within 31 to 120 days.
- The applicant is losing permanent housing and plans to move within 31 to 120 days.
- The caregiver will be unable to be employed if services are not available.
- There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.
- The applicant has behaviors that put the applicant at risk.
- The applicant has behaviors that put others at risk.
- The applicant is at risk of facility placement when needs could be met through community-based services.

Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of emergency need criteria that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of urgent need criteria that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list.

To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list. Once a payment slot is assigned, the department shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

Appendix B: Participant Access and Eligibility**B-3: Number of Individuals Served - Attachment #1 (4 of 4)**

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility**B-4: Eligibility Groups Served in the Waiver**

- a. **1. State Classification.** The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

- 2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

% of FPL, which is lower than 100% of FPL.

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

- Individuals who are eligible under a special income level per 435.236
- Optional eligibility for reasonable classifications of individuals under age 21 per 435.222

Special home and community-based waiver group under 42 CFR §435.217 Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR §435.217

Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the state elects to (*select one*):

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

The following formula is used to determine the needs allowance: patient’s total countable monthly income - 300% of the SSI benefit = patient liability. For participants who have a medical assistance income trust (Miller Trust) an additional \$10 (or higher if court ordered) is allowed to pay for administrative costs: patient’s total countable monthly income – 300% of the SSI benefit - MAIT administrative cost = patient liability.

DHS determines patient liability. Client participation is the amount that a member is required to contribute toward the cost of waiver services. To calculate client participation:

1. Determine only the member’s total gross monthly income.
2. Subtract a maintenance needs allowance of 300% of the current SSI benefit for one person.
3. Add in veteran’s aid and attendance and veteran’s housebound allowance.

The result is the client participation amount.

4. The IMW makes client participation entries on the Automated Benefit Calculation (ABC) system. The IMW notifies the HCBS case manager of the type and amount of client participation to be paid, if any. It is a HCBS case manager’s responsibility to apply the client participation toward a specific service.

For managed care enrollees with a patient liability, DHS will communicate to the MCO the amount of each member's liability. Members will be responsible for remitting their patient liability to their waiver providers. The MCO reduces its payment for a member's waiver services up to the amount of the patient liability.

The capitation rates calculated for MCOs includes a long-term services and supports (LTSS) component which is a blend of institutional services and home and community based services (HCBS). When capitation rates were developed, the LTSS component was calculated with consideration given to patient liability as a possible source of funds used to pay a portion of the services provided through the waiver. For both the institutional and HCBS component of the rate, the average patient liability was subtracted. Therefore, the MCOs are paid net of the average patient liability.

ii. Allowance for the spouse only (select one):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard**Medically needy income standard****The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

The following formula is used to determine the needs allowance: 300% of the SSI benefit and for participants who have a medical assistance income trust (Miller Trust) an additional \$10 (or higher if court ordered) to pay for administrative costs.

DHS determines patient liability. Client participation is the amount that a member is required to contribute toward the cost of waiver services. To calculate client participation:

1. Determine only the member's total gross monthly income.
2. Subtract a maintenance needs allowance of 300% of the current SSI benefit for one person.
3. Add in veteran's aid and attendance and veteran's housebound allowance.

The result is the client participation amount.

4. The IMW makes client participation entries on the Automated Benefit Calculation (ABC) system. The IMW notifies the HCBS case manager of the type and amount of client participation to be paid, if any. It is a HCBS case manager's responsibility to apply the client participation toward a specific service.

For managed care enrollees with a patient liability, DHS will communicate to the MCO the amount of each member's liability. Members will be responsible for remitting their patient liability to their waiver providers. The MCO reduces its payment for a member's waiver services up to the amount of the patient liability.

The capitation rates calculated for MCOs includes a long-term services and supports (LTSS) component which is a blend of institutional services and home and community based services (HCBS). When capitation rates were developed, the LTSS component was calculated with consideration given to patient liability as a possible source of funds used to pay a portion of the services provided through the waiver. For both the institutional and HCBS component of the rate, the average patient liability was subtracted. Therefore, the MCOs are paid net of the average patient liability.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (6 of 7)**

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (7 of 7)**

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility**B-6: Evaluation/Reevaluation of Level of Care**

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

HCBS waiver services must be accessed at least once every calendar quarter by the participant.

As part of the ID waiver service, the equivalent of targeted case management is required for each participant, regardless of delivery system. Case managers and community-based case managers are required to make monthly contacts, either face to face or telephonic, regarding each member in order to establish access to services and to ensure the authorized services are provided as outlined in the participant's service plan to ensure the participant's health, safety and welfare. Case managers, health home coordinators, and community-based case managers are additionally required to make face-to-face contact with the member once per quarter.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

The Iowa Medicaid Enterprise (IME) Medical Services Unit (MSU) is responsible for making all initial level of care decisions. If a member is not currently on Medicaid or is in Medicaid fee-for-service (FFS), the IME's Core Standardized Assessment (CSA) contractor performs the assessment. If a member is enrolled with a MCO, the initial assessment is performed by the MCO, but the IME Medical Services unit conducts the initial LOC determination. LOC decisions also include input from the case manager, community-based case manager, medical professional, and other appropriate professionals.

For FFS members, the annual LOC reevaluation is conducted by the IME MSU. MCOs are responsible for annual LOC reevaluations of their members. The IME MSU reviews and approves all MCO reevaluations that indicate a change in the member's level of care. MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Medical professionals (i.e., licensed physician, physician assistant or advanced registered nurse practitioner) perform the initial LOC evaluation. The IME requires that professionals making the level of care determination are licensed RNs. If the RN is unable to approve a member's level of care, the submitted LOC information is sent to a Physician Assistant or medical doctor make the final level of care determination.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

IME Medical Services Unit uses the following assessment tools in conjunction with the Long Term Care ICF/ID criteria, which reviews the entire body system to determine the level of care. Areas of review in the ICF/ID criteria include: (1) ambulation/mobility; (2) musculoskeletal-disability/paralysis; (3) activities of daily living; (4) elimination; (5) eating skills; (6) sensorimotor; (7) intellectual/vocational; (8) social (9) maladaptive behaviors; (10) healthcare; and (11) psycho-social. Deficits in two of the 11 major life areas are needed for an ICF/ID level of care (LOC) determination

The IME Medical Services Unit uses the following assessments to evaluate and reevaluate applicants and members on the Intellectual Disability (ID) Waiver:

Ages 0-4 Case Management Comprehensive Functional Assessment Tool (Form 470-4694)

Ages 5-15 Supports Intensity Scale® for children (SIS-C) assessment tool

Ages 16+ Supports Intensity Scale® for adults (SIS-A) assessment tool

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The IME LOC Review Coordinators are responsible for determining LOC for member receiving services in both ICF/IDs and the HCBS ID waiver. The review coordinators use the same functional criteria for both programs. LOC functional criteria includes: cognition, ambulation, skin, dressing, behaviors, elimination, medication, bathing/grooming, respiratory and eating.

The Supports Intensity Scale (SIS) is used to assess participants accessing the ID waiver and ICF/ID facility placement. The SIS is a unique, valid and reliable assessment tool specifically designed to measure the level of practical supports required by people with intellectual disabilities to lead normal, independent, and quality lives in society. The SIS must be completed for each participant in the ID waiver and ICF/ID once in a three-year time period. During the two “off” years, an off year assessment tool is utilized for annual level of care redeterminations for adults. The off year assessment reviews and identifies if any significant changes have occurred that would change the results and findings of the current SIS assessment. If there is significant change, a new SIS is administered. For children, the Case Management Comprehensive Functional Assessment Tool Form 470-4694 is used each year. Additional or supplemental information is submitted with the members residing in the ICF/ID. If additional information is need to determine LOC in either HCBS or ICF/ID, the Review Coordinator will request additional information to assure the functional criteria is met for the ICF/ID LOC.

The Form 470-4694, Case Management Comprehensive Assessment Tool currently used for ID waiver services for children under the age of five identifies care needs in the home setting that are the same for the institutional setting. The tool gathers consumer specific information relating to a participant’s medical and physical health, mental health, behavioral and substance use, housing and environment, social skills, transportation needs, education, and vocational skills. This tool is comprehensive and assesses strengths and needs of the participant and gathers information above and beyond what is needed to determine ICF/ID level of care. Within each of the assessment sections, the assessment answers specific questions and allows for comments to be included within the assessment. IME Medical Services may request additional information from the case manager or community-based case manager to clarify or supplement the information submitted with the assessment. The results of the assessment are used to develop the plan of care. Because the same criteria are used for both institutional care and waiver services, the outcome is reliable, valid and fully comparable.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

It is the responsibility of the case manager or community-based case manager to assure the assessment is initiated as required to complete the initial level of care determination. For FFS members, the initial assessment is completed by the IME Core Standardized Assessment (CSA) contractor and sent to the case manager or care coordinator who uploads the assessment to the IME MSU. For MCO members, the MCO is responsible to ensure the CSA is completed and uploaded to the IME MSU. The IME MSU is responsible for determining the level of care based on the completed assessment tool and supporting documentation from medical professionals.

The Continued Stay Review (CSR) is completed annually. The SIS is completed for each participant once in a three-year time period. During the two “off” years, an off year assessment tool is utilized for annual level of care redeterminations for adults. For children under age five, the Case Management Comprehensive Functional Assessment Tool Form 470-4694 is used each year. It is the responsibility of the case manager or community-based case manager to assure the assessment is initiated as required to complete the CSR. For fee-for-service participants, the ISIS system sends out a milestone 60 days prior to the CSR date to remind case manager of the upcoming annual LOC process.

MCOs are responsible for conducting level of care reevaluations for members, using DHS designated tools, at least annually, and when the MCO becomes aware that the member’s functional or medical status has changed in a way that may affect level of care eligibility. Additionally, any member or provider can request a reevaluation at any time. Once the reevaluation is complete, the MCO submits the level of care or functional eligibility information via fax to the IME MSU. The State retains authority for determining Medicaid categorical, financial, level of care or needs-based eligibility and enrolling participants into a Medicaid eligibility category. MCOs track and report level of care and needs-based eligibility reevaluation data, including, but not limited to, reevaluation completion date. MCOs are required to notify DHS of any change in level of care and DHS retains final level of care determination authority. As the State is a neutral third party with final approval authority, there is no conflict of interest.

MCOs are required to employ the same professionals for LOC determinations. Further, MCOs are contractually required to ensure on an ongoing basis that all staff has the appropriate credentials, education, experience and orientation to fulfill the requirements of their position. As applicable based on the scope of services provided under a subcontract, MCOs must ensure all subcontractor staff is trained as well. Staff training shall include, but is not limited to: (i) contract requirements and State and Federal requirements specific to job functions; (ii) training on the MCOs policies and procedures on advance directives; (iii) initial and ongoing training on identifying and handling quality of care concerns; (iv) cultural sensitivity training; (v) training on fraud and abuse and the False Claims Act; (vi) HIPAA training; (vii) clinical protocol training for all clinical staff; (viii) ongoing training, at least quarterly, regarding interpretation and application of utilization management guidelines for all utilization management staff; (ix) assessment processes, person-centered planning and population specific training relevant to the enrolled populations for all care managers; and (x) training and education to understand abuse, neglect, exploitation and prevention including the detection, mandatory reporting, investigation and remediation procedures and requirements. Policies and Procedures Manuals must also be provided to the MCO’s entire staff and be incorporated into all training programs for staff responsible for providing services. Finally, MCOs must maintain documentation to confirm staff training, curriculum, schedules and attendance. DHS reserves the right to review training documentation and require the MCO to implement additional staff training.

MCOs are contractually required to develop and maintain their own electronic community-based case management systems that include functionality to ensure compliance with the State’s 1915(c) HCBS waiver and law. This includes, but is not limited to, the ability to capture and track: (i) key dates and timeframes such as enrollment date, date of development of the care plan, date of care plan authorization, date of initial service delivery, date of level of care and needs reassessments and dates of care plan updates and the functionality to notify the community-based case manager or care coordinator of care plan, assessment and reassessment deadlines; (ii) the care plan; (iii) all referrals; (iv) level of care assessment and reassessments; (v) needs assessments and reassessments; (vi) service delivery against authorized services and providers; (vii) actions taken by the community-based case manager or care coordinator to address service gaps; and (viii) case notes.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (*select one*):

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

FFS

The IME CSA contractor is responsible for submitting timely level of care reevaluations of members. Reevaluations are considered timely if they are completed within twelve (12) months of the previous evaluation. Reevaluations of FFS members are tracked in the DHS Individualized Services Information System (ISIS). An ISIS milestone is sent out to the FFS CSA contractor 60 days before the reevaluation is due.

On a weekly basis, an ISIS CSR report is extracted to identify FFS overdue reevaluations. The list is sent to the management team for DHS Targeted Case Management for resolution. The DHS TCM submits a weekly status report to the designated HCBS program manager for monitoring with conferencing as needed.

A CSR or re-evaluation report is also available through ISIS to track overdue reevaluations and is monitored by Medical Services, the Bureau of Long Term Care (BLTC), and IME.

MCO

Reevaluations of MCO members are also tracked in the DHS Individualized Services Information System (ISIS) for IME oversight. However, MCOs are also responsible for recording timely completion of level of care reevaluations of members. One hundred percent (100%) of member level of care reevaluations must be completed within twelve (12) months of the previous evaluation. ISIS is queried weekly to monitor the status of MCO LOC determinations. This information is shared with MCO account managers. DHS reserves the right to audit MCO application of level of care criteria to ensure accuracy and appropriateness.

MCOs are contractually required to develop and maintain their own electronic community-based case management systems that include functionality to ensure compliance with the State's 1915(c) HCBS waiver and law. This includes, but is not limited to, the ability to capture and track: (i) key dates and timeframes such as enrollment date, date of development of the care plan, date of care plan authorization, date of initial service delivery, date of level of care and needs reassessments and dates of care plan updates and the functionality to notify the community-based case manager or care coordinator of care plan, assessment and reassessment deadlines; (ii) the care plan; (iii) all referrals; (iv) level of care assessment and reassessments; (v) needs assessments and reassessments; (vi) service delivery against authorized services and providers; (vii) actions taken by the community-based case manager or care coordinator to address service gaps; and (viii) case notes.

Should MCO reevaluations not be completed in a timely manner, DHS may require corrective action(s) and implement intermediate sanctions in accordance with 42 CFR 438, Subpart I. The nature of the corrective action(s) will depend upon the nature, severity and duration of the deficiency and repeated nature of the non-compliance. The non-compliance corrective actions may be instituted in any sequence and include, but are not limited to, a written warning, formal corrective action plan, withholding of full or partial capitation payments, suspending auto-assignment, reassigning an MCO's membership and responsibilities, appointing temporary management of the MCO's plan, and contract termination. In the event of non-compliance with reevaluation timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Evaluation documents for initial LOC determinations, and reevaluation documents exhibiting a change in LOC, are faxed to the IME MSU regardless of delivery system (i.e., FFS participants and MCO members) and placed in "OnBase." OnBase is an IME system that stores documents electronically and establishes workflow. In addition, the waiver participant's case manager or community-based case manager is responsible for service coordination for each participant. These providers maintain a working case file for each member and must maintain the records for a period of five years from the date of service. The case file includes all assessments, both initial and ongoing, completed during the time the participant was receiving waiver services. MCOs also maintain electronic case management systems that are used to capture and track all evaluations and reevaluations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. Sub-assurance: *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

LC-a1: IME will measure the number and percent of approved LOC decisions.

Numerator: # of completed LOC; Denominator: # of referrals for LOC.

Data Source (Select one):

Other

If 'Other' is selected, specify:

FFS and MCO members will be pulled from ISIS for this measure. IME MSU completes all initial level of care determinations for both FFS and MCO populations.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>

<p>Other Specify:</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;">contracted entity</div>	<p>Annually</p>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>	

Data Aggregation and Analysis:

<p>Responsible Party for data aggregation and analysis (<i>check each that applies</i>):</p>	<p>Frequency of data aggregation and analysis(<i>check each that applies</i>):</p>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>

b. Sub-assurance: *The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

LC-c1: The IME shall determine the number and percent of initial level of care decisions that were accurately determined by applying the approved LOC criterion using standard operating procedures. Numerator: # of LOC decisions that were accurately determined by applying the correct criteria as defined in the waiver; Denominator: # of reviewed LOC determinations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

IME MQUIDS and OnBase

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;">+/- 5% with 95% confidence level</div>
Other	Annually	Stratified

<p>Specify:</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;">Contracted entity</div>		<p>Describe Group:</p> <div style="border: 1px solid black; padding: 2px;"> IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%) </div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p>

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input style="width: 100%; height: 30px;" type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Data for completed LOC is collected quarterly through reports generated through ISIS, MQUIDS, and OnBase. This data is monitored for trends from an individual and systems perspective. Monthly a random sample of LOC decisions is selected from each reviewer. IQC activity is completed on the random sample. This level of scrutiny aids in early detection of variance from the stated LOC criteria.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The state's Medical Services Unit performs internal quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred, the unit undertakes additional training for staff.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 30px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DHS is dedicated to serving individuals in the communities of their choice within the resources available and to implementing the United States Supreme Court's mandate in *Olmsted v. L.C.* As such, services are provided in a manner that facilitates maximum community placement and participation for members that require LTSS.

In accordance with 42 CFR 441.301 and the Iowa Administrative Code 441-90.5(1)b and 441-83, service plans must reflect the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan, developed through a "person-centered" planning process, must reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports.

The person-centered process is holistic in addressing the full array of medical and non-medical services and supports to ensure the maximum degree of integration and the best possible health outcomes and member satisfaction. Moreover, members are given the necessary information and support to ensure their direction of the process to the maximum extent possible, and to empower them to make informed choices and decisions regarding the services and supports received.

During enrollment of fee-for-service members, ISIS requires that case managers (CM) attest to having offered a choice between HCBS or institutional services. Choice is verified by: (1) marking the waiver box on the application; (2) sending a written request asking for waiver services; or (3) verbally confirming the member's choice with the income maintenance worker and the case manager documents the conversation.

Further, there are waiver informational brochures available to share with members and their parents/guardians. Brochures are available at each of the DHS county offices. Information is also available on the IME and MCO websites. The brochures include information on eligibility, service descriptions, and the application process. Once a member begins the enrollment process and has a case manager or community-based case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a member's plan of care.

MCO

MCO community based case managers are required ensure that members are offered choice according to their respective MCO processes and forms, which are reviewed and approved by DHS.

The IME's contractor for HCBS Oversight conducts monthly ride-along for MCO service plan coordination and evaluates compliance with service planning requirements, including choice between institutional and HCBS services. Feedback is provided to the MCO account managers, who then follow up on any necessary corrective actions.

In addition, the IME Medical Services Unit (MSU) reviews the person centered service plan to determine if provider choice (including CCO) is offered.

The HCBS Quality Oversight Unit (QOU), during the IPES member telephone surveys, asks members if they are offered choice of providers. The HCBS regional specialists (part of the HCBS QOU) as part of the IDT/CBCM Ride Along activity, identifies if provider choice is offered during the IDT meetings.

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

FFS

Freedom of Choice forms for fee-for-service members is documented in member service plans and in ISIS.

MCO

MCOs are responsible for maintaining records that fully disclose the extent of services provided to members for a minimum of seven years, and must furnish such information to duly authorized and identified agents or representatives of the state and federal governments.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Iowa DHS adopts the policy as set forth in Title VI of the Civil Rights Act prohibiting national origin discrimination as it affects people with limited English proficiency. DHS shall provide for communication with people with limited English proficiency, including current and prospective patients or clients, family members and participants to ensure them an equal opportunity to benefit from services. DHS has developed policies and procedures to ensure meaningful access for people with limited English proficiency. This includes procedures to:

- Identify the points of contact where language assistance is needed.
- Identify translation and interpretation resources, including their location and their availability.
- Arrange to have these resources available in timely manner.
- Determine the written materials and vital documents to be translated, based on the populations with limited English proficiency and ensure their transition.
- Determine effective means for notifying people with limited English proficiency of available translation services available at no cost.
- Train department staff on limited English proficiency requirements and ensure their ability to carry them out.
- Monitor the application of these policies on at least an annual basis to ensure ongoing meaningful access to services.

All applications and informational handouts are printed in Spanish. In addition, the contract with IME Member Services requires that a bilingual staff person be available to answer all telephone calls, emails and written inquiries. They also work with interpreters if another spoken language is needed. All local DHS offices have access to a translator if a bilingual staff person is not available. DHS includes this policy as part of their Policy on Nondiscrimination that can be found in the DHS Title I General Departmental Procedures in the Department Employee Manual.

Locally, each county DHS office utilizes the resources that are available to them. For example, in larger metropolitan areas, local offices have staff that is fluent in Spanish, Bosnian, and Southeastern Asian languages. Some offices utilize translators from DHS Refugee Services. Other areas of the state have high Russian populations and access the translators in the area. All county offices have access to the Language Line service where they may place a telephone call and request a translator when one is not available at the local office. Medicaid beneficiaries may call the IME Member Services unit with any questions relating to Medicaid, including waiver services. Member Services has translation capabilities similar to the local DHS offices and uses the Language Line to address any language when Member Services does not have an interpreter on staff.

MCOs must conform to DHS policies regarding meaningful access to the waiver by limited English proficient persons, and to deliver culturally competent services in accordance with 42 CFR 438.206.

-MCOs must provide language services at no cost to limited English proficiency members, and all written materials shall be provided in English and Spanish, as well as any additional prevalent languages identified by the State or through an analysis of member enrollment (i.e., any language spoken by at least five percent (5%) of the general population in the MCO's service area).

-MCOs must provide oral interpretation services free of charge to each member (this applies to all non-English languages, and is not limited to prevalent languages), and MCOs must notify all members that oral interpretation and translated written information is available and how to access those services. Written materials must include taglines in prevalent languages regarding how to access materials in alternative languages.

-MCOs must ensure that service plans reflect cultural considerations of the member and that service plan development is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b).

-MCOs must operate member services helplines that are available to all callers, and an automated telephone menu options must be made available in English and Spanish.

-MCOs must maintain member websites and mobile applications available in English and Spanish that are accessible and functional via cell phone.

All MCO developed member communications, including substantive changes to previously approved communications, must be approved by DHS prior to use/distribution.

Appendix C: Participant Services

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Adult Day Care		
Statutory Service	Day Habilitation		
Statutory Service	Prevocational Services		
Statutory Service	Residential Based Supported Community Living		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Extended State Plan Service	Home Health Aide Services		
Extended State Plan Service	Nursing		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Independent Support Broker		
Supports for Participant Direction	Individual Directed Goods and Services		
Supports for Participant Direction	Self Directed Community Support and Employment		
Supports for Participant Direction	Self Directed Personal Care		
Other Service	Consumer Directed Attendant Care (CDAC) - skilled		
Other Service	Consumer Directed Attendant Care (CDAC) - unskilled		
Other Service	Home and Vehicle Modification		
Other Service	Interim Medical Monitoring and Treatment		
Other Service	Personal Emergency Response or Portable Locator System		
Other Service	Supported Community Living		
Other Service	Transportation		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on regular or intermittent basis in a day care center. Supports provided during day care would be ADLs and IADLs. Included are personal cares (ie: ambulation, toileting, feeding, medications) or intermittent health-related cares, not otherwise paid under other waiver or state plan programs.

Meals provided as part of these services shall not constitute a full nutritional day; each meal is to provide 1/3 of daily dietary allowances.

Adult day care does not cover therapies: OT, PT or speech.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is 15-minutes (up to 4 units per day), a half day (1.25 to 4 hours per day), or a full day (4.25 to 8 hours per day).

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Adult Day Care Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Adult day care providers shall be agencies that are certified by the Department of Inspections and Appeals (DIA) as being in compliance with the standards for adult day services programs at IAC 481—Chapter 70.

Other Standard (specify):

(1) At least 18 years of age.
(2) Qualified by training as required by the DIA, the ADC licensing entity.
(3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based service.

The adult day service agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Day Habilitation means Provision of regularly scheduled activities such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the participant’s person-centered plan. Day habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual’s person-centered services and supports plan, such as physical, occupational, or speech therapy.

Day habilitation services are not limited to fixed-site facilities. Day habilitation may be furnished in a variety of settings in the community other than the person’s private residence. For members living in a residential care facility, Day Hab services provided in the facility are not considered to be provided in the member’s home. Services provided in a residential care facility setting must be provided separate from the participant’s private residence or other residential living arrangements.

When transportation is provided between the participants’ place of residence and the Day Habilitation service site(s) and is provided as a component part of this service, the cost of transportation is included in the rate paid to providers of day habilitation services.

Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member’s home.

The first line of prevention of duplicative billing for similar types of day programs (Day Habilitation, pre-vocational, supported employment and Adult day care) is the member’s case manager. The case manager is responsible for the authorization and monitoring of services in a member’s plan of care. If the case manager authorizes similar services during the same time period, they are responsible to assure that the services are being delivered as authorized. The ISIS system generates a review report to assist the case manager. The report identifies all services that have been billed for a specific time period (ex. one month). The case manager is able to view the service billed to the individual member, the amount of the service billed and the provider. The case manager is able to compare what has been billed by the provider to what is ordered in the plan of care. The department also conducts post audit reviews of providers to review the billing of providers to assure that the services provided have documentation to support the billing.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service may be a 15- minute unit or a full day (4.25 to 8 hours). For the family training option, a unit of service is a 15 minute unit. The units of family training option services are limited to a maximum of 40, 15-minute units per month. If additional family training service units are needed, an exception to policy (ETP) may be requested by the member, case manager or community based case manager. An ETP requires the Department to review and prior authorization any additional services above the 40 units. Services may be provided in any community based setting, but not be provided in the member’s home, except when providing the family training component of day habilitation.

Meals provided as part of this service shall not constitute a full nutritional regimen of 3 meals per day.

Transportation provided to and from a member’s place of residence is not a required component of Day Habilitation.

The individual budget limit will be based on the member’s authorized service plan and the need for the services available to be converted to the CCO budget.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	CQL Accredited
Agency	CARF Accredited

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

CQL Accredited

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies accredited by the Council on Quality and Leadership.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

CARF Accredited

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation pursuant to Iowa Administrative Code 441- 78.41(14),

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

“Prevocational services” means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member’s experientially based informed choice regarding the goal of individual employment. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member’s local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member, and their family, guardian or legal representative to introduce them to supported employment and explore the member’s employment goals and experiences
2. business tours,
3. informational interviews,
4. job shadows,
5. benefits education and financial literacy,
6. assistive technology assessment, and
7. other job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2.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.

b. Setting. Prevocational services shall take place in community-based nonresidential settings.

c. Concurrent services. A member’s individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

Transportation provided as a component of prevocational services and the cost of transportation is included in the rate paid to providers of prevocational services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is one hour.

Exclusions. Prevocational services payment shall not be made for the following:

- (1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.
- (2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- (3) Compensation to members for participating in prevocational services.
- (4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g. hospitals, nursing homes), and support for members volunteering to benefit the service provider is prohibited.
- (5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.
- (6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

Limitations.

- (1) Time limitation for members starting prevocational services. For members starting prevocational services after May 4, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in Prevocational Services is also working in either individual or small group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or
2. The member who is in Prevocational Services is also working in either individual or small group community employment for less than the number of hours per week the member wants, as identified in the member's current service plan, but the member has services documented in his/her current service plan, or through another identifiable funding source (e.g. IVRS), to increase the number of hours the member is working in either individual or small group community employment; or
3. The member is actively engaged in seeking individual or small group community employment or individual self-employment, and services for this are included in his/her current service plan, or services funded through another identifiable funding source (e.g. IVRS) are documented in the member's service plan; or
4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months and has been denied and/or placed on a waiting list by both Medicaid and IVRS; or
5. The member has been receiving Individual Supported Employment service (or comparable services available through IVRS) for at least 18 months without obtaining seeking individual or small group community employment or individual self-employment.
6. The member is participating in career exploration activities

- (2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan. This time limit can be extended as stated in paragraphs "1" through "6." If the criteria in paragraphs 1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF Accredited
Agency	CQL Accredited

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

CARF Accredited

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Accredited by the Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- (1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.
- (2) A person providing direct support shall not be an immediate family member of the member. Immediate family member is defined as a parent, step parent, sibling or step sibling of the member.
- (3) A person providing direct support shall, within 6 months of hire or within 6 months of May 04, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs.
- (4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

CQL Accredited

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers accredited by the Council on Quality and Leadership.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- (1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.
- (2) A person providing direct support shall not be an immediate family member of the member. Immediate family member is defined as a parent, step parent, sibling or step sibling of the member.
- (3) A person providing direct support shall, within 6 months of hire or within 6 months of May 04, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs.
- (4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually..

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four year

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Based Supported Community Living

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid. The services under the Intellectual Disability Waiver, including the RBSCCL service, are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with the waiver objectives of avoiding institutionalization. The member's case manager is responsible for assuring state plan services, including EPSDT, are appropriately authorized in the member's services plan as needed.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“d.”

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program

The cost of transportation services is provided through the tiered rate fee schedule funding and is used to conduct business errands and essential shopping, travel to and from work or day programs, and to reduce social isolation. Transportation, the waiver service, is not available to members accessing RBSCCL services. Transportation to and from school are not reimbursable under the RBSCCL service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is a day. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

The services under the Intellectual Disabilities Waiver, including RBSCCL services, are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	RCF/ID
Agency	Foster care
Agency	Certified Supported Community Living Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Residential Based Supported Community Living

Provider Category:

Agency

Provider Type:

RCF/ID

Provider Qualifications

License (specify):

Agencies licensed by the department as residential facilities for intellectually disabled children under Iowa Administrative Code 441—Chapter 116.

Certificate (specify):

Other Standard (specify):

Meet the standards in IAC 77.37(23) for Residential-based supported community living service providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Residential Based Supported Community Living

Provider Category:

Agency

Provider Type:

Foster care

Provider Qualifications

License (specify):

Agencies licensed by the department as group living foster care facilities under Iowa Administrative Code 441—Chapter 114.

Certificate (*specify*):

Other Standard (*specify*):

Meet the standards in IAC 77.37(23) for Residential-based supported community living service providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Residential Based Supported Community Living

Provider Category:

Agency

Provider Type:

Certified Supported Community Living Providers

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Providers certified by the HCBS Quality Oversight Unit to provide Supported Community Living pursuant to Iowa Administrative Code 441 - 77.37.

Other Standard (*specify*):

Meet the standards in IAC 77.37(23) for Residential-based supported community living service providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite is to enable the member to remain in the member's current living situation. Staff to member ratios shall be appropriate to the member's needs as determined by the member's interdisciplinary team. The interdisciplinary team shall determine if the member shall receive basic individual respite, specialized respite or group respite. Basic individual respite means respite provided on a staff-to-member ratio of one to one to members without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse; group respite is respite provided on a staff to member ratio of less than one to one; specialized respite means respite provide on a staff to member ratio of one to one to members with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

The state of Iowa allows respite services to be provided in variety of settings and by different provider types. All respite services identified in Appendix J fall within the definition of basic, specialized or group respite. For reporting purposes in Appendix J, the following provider types are listed as separate respite service:

- Home Health Agency (HHA) may provide basic, group, and specialized respite
- Residential Care Facility for persons with Intellectual Disabilities (RCF/ID) may provide basic, group or specialized respite
- Homecare and Non-Facility based providers may provide basic, group and specialized respite
- Hospital or Nursing Facility – skilled, may provide basic, group and specialized respite
- Organized Camping programs (residential weeklong camp, group summer day camp, teen camp, group specialized summer day camp) may provide basic, group and specialized respite
- Child Care Centers may provide basic, group and specialized respite
- Nursing Facility may provide basic, group or specialized respite
- Intermediate Care facilities for persons with Intellectual Disabilities (ICF/ID) may provide basic, group or specialized respite

The payment for respite is connected to the staff to member ratio. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when provided in a residential 24 hours camp program.

Federal Financial Participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services provided outside the member’s home, such as a licensed facility, shall not be reimbursable if the living unit where the respite is provided is reserved for another person on a temporary leave of absence. Respite may be provided in facilities (RCF/ID, ICF/ID etc.). This language is in the Iowa Administrative Code for respite services and is included in the renewal application to avoid the duplication of payment between Medicaid and the facility. Facilities are paid for reserved bed days as part of the facility per diem payment rate. Facilities are paid for days when the member is out of the facility for hospitalization, home visits, vacations, etc. ID waiver funds cannot be used to pay for a person to stay in the facility in a bed that is being paid for as a reserved bed day.

- a. Staff-to-consumer ratios shall be appropriate to the individual needs of the member as determined by the member’s interdisciplinary team.
- b. A unit of service is a 15 minute unit.
- c. Payment for respite services shall not exceed \$7,334.62 per the member’s waiver year.
- d. The service shall be identified in the member’s individual comprehensive plan.
- e. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS ID waiver supported community living services, Medicaid or HCBS ID nursing, or Medicaid or HCBS ID home health aide services.
- f. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the member is attending a 24 hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member. The current IME policy identifies that respite is not appropriate for a paid caregiver. If respite is needed, another CDAC provider can be employed. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441-83.60(249A).
- h. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- i. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

The individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget.

Service Delivery Method *(check each that applies):*

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies):*

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Foster Care
Agency	Nursing facilities, intermediate care facilities for the intellectually disabled, and hospitals
Agency	RCF/ID
Agency	Respite care providers certified under the Intellectual Disability or Brain Injury waivers.
Agency	Camps
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite**Provider Category:**

Agency

Provider Type:

Foster Care

Provider Qualifications**License** (*specify*):

Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

Certificate (*specify*):**Other Standard** (*specify*):

Respite providers shall meet the following conditions:

Providers shall maintain the following information that shall be updated at least annually:

- The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
- An emergency medical care release.
- Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.
- The consumer's medical issues, including allergies.
- The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

- Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.
- Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
- Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.
- Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing facilities, intermediate care facilities for the intellectually disabled, and hospitals

Provider Qualifications

License (specify):

Certificate (specify):

Nursing facilities, intermediate care facilities for the intellectually disabled, and hospitals enrolled as providers in the Iowa Medicaid program. Facilities must be licensed as a nursing facility or intermediate care facilities for the intellectually disabled, or a hospital by the Iowa Department of Inspections and Appeals (DIA)

Other Standard (specify):

Respite providers shall meet the following conditions:

Providers shall maintain the following information that shall be updated at least annually:

- The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
- An emergency medical care release.
- Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.
- The consumer's medical issues, including allergies.
- The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

- Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.
- Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
- Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.
- Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit, Department of Inspections and Appeals

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

RCF/ID

Provider Qualifications**License** (*specify*):

A facility must be licensed as a residential care facilities for persons with intellectual disabilities by the Iowa Department of Inspections and Appeals (DIA)

Certificate (*specify*):
Other Standard (*specify*):

Respite providers shall meet the following conditions:

Providers shall maintain the following information that shall be updated at least annually:

- The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
- An emergency medical care release.
- Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.
- The consumer's medical issues, including allergies.
- The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

- Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.
- Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
- Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.
- Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Service, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Respite care providers certified under the Intellectual Disability or Brain Injury waivers.

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Respite care providers certified by the department HCBS Quality Oversight Unit under the Intellectual Disability or Brain Injury waivers as part of Iowa Administrative Code 447-77.37 and 77.39.

Other Standard (*specify*):

Respite providers shall meet the following conditions:
 Providers shall maintain the following information that shall be updated at least annually:
 -The consumer’s name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
 -An emergency medical care release.
 -Emergency contact telephone numbers such as the number of the consumer’s physician and the spouse, guardian, or primary caregiver.
 -The consumer’s medical issues, including allergies.
 -The consumer’s daily schedule which includes the consumer’s preferences in activities or foods or any other special concerns.
 Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.
 All medications shall be stored in their original containers, with the accompanying physician’s or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer’s name.
 In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.
 Policies shall be developed for:
 -Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse’s, guardian’s or primary caregiver’s signature is required to verify receipt of notification.
 -Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
 -Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.
 -Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
 A facility providing respite under this subrule shall not exceed the facility’s licensed capacity, and services shall be provided in locations consistent with licensure.
 Respite provided outside the consumer’s home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Camps

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):

Camps accredited by the American Camping Association (ACA). The ACA-Accreditation Program:

- Educates camp owners and directors in the administration of key aspects of camp operation, program quality, and the health and safety of campers and staff.
- Establishes guidelines for needed policies, procedures, and practices for which the camp is responsible for ongoing implementation.
- Assists the public in selecting camps that meet industry-accepted and government recognized standards. ACA's Find a Camp database provides the public with many ways to find the ideal ACA-accredited camp.

Mandatory standards include requirements for staff screening, emergency exits, first aid, aquatic-certified personnel, storage and use of flammables and firearms, emergency transportation, obtaining appropriate health information, among others.

www.ACAcamps.org/accreditation

Other Standard (*specify*):

Respite providers shall meet the following conditions:
 Providers shall maintain the following information that shall be updated at least annually:
 -The consumer’s name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
 -An emergency medical care release.
 -Emergency contact telephone numbers such as the number of the consumer’s physician and the spouse, guardian, or primary caregiver.
 -The consumer’s medical issues, including allergies.
 -The consumer’s daily schedule which includes the consumer’s preferences in activities or foods or any other special concerns.
 Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.
 All medications shall be stored in their original containers, with the accompanying physician’s or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer’s name.
 In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.
 Policies shall be developed for:
 -Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse’s, guardian’s or primary caregiver’s signature is required to verify receipt of notification.
 -Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
 -Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.
 -Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
 A facility providing respite under this subrule shall not exceed the facility’s licensed capacity, and services shall be provided in locations consistent with licensure.
 Respite provided outside the consumer’s home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.

Other Standard (*specify*):

Respite providers shall meet the following conditions:
 Providers shall maintain the following information that shall be updated at least annually:
 -The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
 -An emergency medical care release.
 -Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.
 -The consumer's medical issues, including allergies.
 -The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.
 Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.
 All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.
 In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.
 Policies shall be developed for:
 -Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.
 -Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
 -Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.
 -Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
 A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.
 Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

Expected outcome of service. The expected outcome of this service 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. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with

prospective employers to

customize, create or carve out a position for the member; employer needs analysis).

10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking

promotion from an existing

employer).

13. Re-employment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on the job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.

Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3. Identification of the long-term supports necessary for the individual to operate the business.

Long-term job coaching. Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in service provider's organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider's organization were the provider not being paid to provide the job coaching to the member.

Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized and service plan are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
13. Transportation of the member during service hours.
14. Career exploration services leading to increased hours or career advancement.

Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10)“b”(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
3. Ongoing benefits education and support.

The hours of support tier assignment for long-term job coaching is based on the identified needs of the member as documented in the member's comprehensive service plan and adjusted when higher support needs are determined.

Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration, or development of strengths and skills that contribute to successful participation in individual community employment.

Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member's residence.

Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.
3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.
11. Transportation of the member during service hours.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service for Individual Supported Employment is 15 minutes

A unit of service for Small group Employment is 15 minutes

A unit of service for Long-Term Job Coaching is a monthly unit of service. The hours of support tier assignment for long-term job coaching is based on the identified needs of the member as documented in the member's comprehensive service plan and adjusted when higher support needs are determined based on the hours of support the member requires each month.

Service requirements for all supported employment

- (1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.
- (2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.
- (3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.
- (4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).
- (5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.
- (6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

Limitations. Supported employment services are limited as follows:

- (1) In the ID waiver, the total monthly cost of all supported employment services may not exceed \$3,029.00 per month.
- (2) Individual supported employment is limited to 240 units per calendar year.
- (3) Long-term job coaching is limited in accordance with 441—subrule 79.1(2), which states that the total monthly cost for all supported employment services not to exceed \$3,059.29 per month.

Exclusions. Supported employment services payments shall not be made for the following:

- (1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.
- (2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.
- (3) Subsidies or payments that are passed through to users of supported employment programs.
- (4) Training that is not directly related to a member's supported employment program.
- (5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.
- (6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational

- services and career exploration activities.
- (7) Tuition for education or vocational training.
 - (8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.
 - (9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

For member's choosing the Consumer Choices Option, the individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	ICCD Accredited
Agency	CARF Accredited
Agency	Joint Accredited
Agency	CAFC Accredited
Agency	CQL Accredited

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

ICCD Accredited

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

An agency that is accredited by the International Center for Clubhouse Development.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- (1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.
- (2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
- (3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
- (4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

CARF Accredited

Provider Qualifications

License (specify):

--

Certificate (*specify*):

--

Other Standard (*specify*):

An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- (1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.
- (2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
- (3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
- (4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Joint Accredited

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- (1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.
- (2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
- (3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
- (4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

CAFC Accredited

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- (1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.
- (2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
- (3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
- (4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

CQL Accredited

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- (1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.
- (2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
- (3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
- (4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Home Health Aide Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Home health aide services are an extension of the State Plan and are personal or direct care services provided to the member, which are not payable under Medicaid as set forth in Iowa Administrative Code rule 441—78.9(249A). All state plan services, including EPSDT, must be accessed before seeking payment through the waiver. This waiver service is only provided to individuals age 21 and over. All medically necessary Home Health Aide services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. The scope and nature of waiver home health services do not differ from home health aid services furnished under the State Plan. Services are defined in the same manner as provided in the approved State Plan. Skilled nursing care is not covered. The provider qualifications specified in the State plan apply.

Components of the waiver home health service include:

- (1) Observation and reporting of physical or emotional needs.
- (2) Helping a member with bath, shampoo, or oral hygiene.
- (3) Helping a member with toileting.
- (4) Helping a member in and out of bed and with ambulation.
- (5) Helping a member reestablish activities of daily living.
- (6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.
- (7) Performing incidental household services which are essential to the member’s health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

Home health services are provided under the Medicaid State Plan services until the limitations have been reached. Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973.

Overlapping of state plan and waiver services is avoided by the use of a case manager who manages all services and the entry of the service plan into the ISIS system. All medically necessary Home Health Aide services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services shall include unskilled medical services and shall exceed those services provided under HCBS ID waiver supported community living or the Medicaid state plan home health aide benefit. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

- a. Services shall be included in the consumers individual comprehensive plan.
- b. A unit is one hour.
- c. A maximum of 14 units are available per week. If additional home health aide service is needed, a request for an exception to policy may be submitted to the Department for review.

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Home Health Aide Services

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License (specify):

Certificate (specify):

In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.

Other Standard (specify):

The home health agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Nursing

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. Nursing services under the Medicaid State Plan must be exhausted first. Nursing Care Services differ only in duration of services from Medicaid State Plan. Nursing Care Services under the waiver do not need to show an attempt to have a predictable end.

Overlapping of services is avoided by the use of a case manager who manages all services and the entry into the ISIS system. This service is only provided to members age 21 and over. All medically necessary nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is an hour. A maximum of ten units are available per week.

The individuals service plan will show how the consumer health care needs are being met. Services must be authorized in the service plan. The Iowa Dept. of Human Services' case manager will monitor the plan.

This waiver service is only provided to individuals age 21 and over. All medically necessary Nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Nursing

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):

In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.

Other Standard (*specify*):

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training.
- (3) Subject to background checks prior to direct service delivery.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Management Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

The Financial Management Service (FMS) is necessary for all members choosing the self-direction option, and will be available only to those who self direct. The FMS will enroll as a Medicaid Provider. The FMS will receive Medicaid funds in an electronic transfer and will pay all service providers and employees electing the self-direction option. The FMS services are provided to ensure that the individualized budgets are managed and distributed according to the budget developed by each member and to facilitate the employment of service workers by members. The Iowa Department of Human Services will designate the Financial Management Service entities as Organized health care delivery system.

Responsibilities of the financial management service. The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.
 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 6. Preparing and issuing employee payroll checks.
 7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
 8. Processing federal advance earned income tax credit for eligible employees.
 9. Refunding over-collected FICA, when appropriate.
 10. Refunding over-collected FUTA, when appropriate
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The FMS currently has an upper payment limit of \$66.95 a month.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Institution

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Financial Institution

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

As defined in IAC 441 Chapter 77.30(13), the financial institution shall either:

- (1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or
- (2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

- b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.
- c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.
- d. The financial institution shall enroll as a Medicaid provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Independent Support Broker

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Independent Support Brokerage service is necessary for all members who chose the self-direction option. This is a service that is included in the member's Budget. The Independent Support Brokerage will be chosen and hired by the member. The ISB will work with the member to guide them through the person centered planning process and offer technical assistance and expertise for selecting and hiring employees and/or providers and purchasing supports.

The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is necessary for members who choose the self-direction option at a maximum of 30 hours a year. When a member first initiates the self-direction option, the Independent Support Broker will be required to meet with the member at least monthly for the first four months and quarterly after that. If a member needs additional support brokerage service, the member will need prior authorization from the state.

Service Delivery Method *(check each that applies):*

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies):*

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Support Broker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Independent Support Broker

Provider Category:

Individual

Provider Type:

Individual Support Broker

Provider Qualifications**License** (*specify*):
Certificate (*specify*):
Other Standard (*specify*):

Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications:

- The broker must be at least 18 years of age.
- The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.
- The broker shall not provide any other paid service to the member.
- The broker shall not work for an individual or entity that is providing services to the member.
- The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
- The broker must complete independent support brokerage training approved by the department.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The member, Financial Management System (FMS) Provider and Iowa Department of Human Services are responsible for the verification of provider qualifications. The member verifies that employees hired have the skills and training needed to provide direct services. The FMS is responsible for the employer tasks such as completing employee background checks, verify employee citizenship or aliens status, and assuring wages are within the Department of Labor standards. The Department verifies the employee criminal and abuse background checks.

Frequency of Verification:

Once initially trained, the Individual Support Broker is placed on a Independent Support Brokerage registry that is maintained at the Iowa Department of Human Services Iowa Medicaid Enterprise.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member’s service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member’s budget without compromising the member’s health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member’s needs.
6. Not be available through another source.

Participants (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their case manager and ISB to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Individual directed goods and services must be documented on the individual budget. The individual budget limit will be based on the service plan and the need for the services available to be converted. A utilization adjustment rate is applied to the individual budget amount. Please see Section E- 2- b ii for details on how the CCO budget is created.

The following goods and services may not be purchased using a self-directed budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

Service Delivery Method *(check each that applies):*

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies):*

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Directed Goods and Services
Agency	Individual Directed Goods and Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Individual Directed Goods and Services

Provider Category:

Individual

Provider Type:

Individual Directed Goods and Services

Provider Qualifications**License** (*specify*):
Certificate (*specify*):
Other Standard (*specify*):

Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

a. A business providing individual-directed goods and services shall:

- (1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
- (2) Have current liability and workers' compensation coverage.

b. An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing individual-directed goods and services shall:

- (1) Be at least 18 years of age.
- (2) Be able to communicate successfully with the member.
- (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
- (5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of individual-directed goods and services shall:

- (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
- (2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The member, Financial Management System (FMS) Provider and Iowa Department of Human Services are responsible for the verification of provider qualifications. The member verifies that employees hired have the skills and training needed to provide direct services. The FMS is responsible for the employer tasks such as completing employee background checks, verify employee citizenship or aliens status, and assuring wages are within the Department of Labor standards. The Department verifies the employee criminal and abuse background checks.

Frequency of Verification:

Verification of qualifications occurs at the time of initial use by a member in the CCO program

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Individual Directed Goods and Services

Provider Category:

Agency

Provider Type:

Individual Directed Goods and Services

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Members who elect the consumer choices option may choose to purchase individual directed goods and services. Providers must have current liability and workers' compensation coverage as required by law.

All personnel providing self-directed community supports and employment shall:

- (1) Be at least 18 years of age.
- (2) Be able to communicate successfully with the member.
- (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
- (5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of individual-directed goods and services shall:

- (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
- (2) Submit invoices and time sheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and time sheets are received after this 30-day period.

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, Financial Management System (FMS) Provider and Iowa Department of Human Services are responsible for the verification of provider qualifications. The member verifies that employees hired have the skills and training needed to provide direct services. The FMS is responsible for the employer tasks such as completing employee background checks, verify employee citizenship or aliens status, and assuring wages are within the Department of Labor standards. The Department verifies the employee criminal and abuse background checks.

Frequency of Verification:

Verification of qualifications occurs at the time of initial use by a member in the CCO program

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Self Directed Community Support and Employment

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager. Services may include payment for social skills development, career placement, vocational planning, and independent daily living activity skill development. The outcome of this service is to maintain integrated living in the community or to sustain competitive employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or 2) payments that are passed through to users of supported employment services.

Transportation may be covered for members from their place of residence and the employment site as a component of this service and the cost may be included in the rate.

The following are examples of supports a member can purchase to help the member live and work in the community:

- o Career counseling
- o Career preparation skills development
- o Cleaning skills development
- o Cooking skills development
- o Grooming skills development
- o Job hunting and career placement
- o Personal and home skills development
- o Safety and emergency preparedness skills development
- o Self-direction and self-advocacy skills development
- o Social skills development training
- o Supports to attend social activities
- o Supports to maintain a job
- o Time and money management
- o Training on use of medical equipment
- o Utilization of public transportation skills development
- o Work place personal assistance

Participants (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their case manager and ISB to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community support and employment services must be identified on the individual budget plan. The individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget. The ID waiver allows for the following eight ID waiver services to be converted to create a CCO budget:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

Once authorized in the monthly CCO budget, the member must use the budget to get their assessed needs met. It is the responsibility of the member's case manager or community based case manager to monitor the member's CCO use to assure that the member is using the budget to get their service needs met.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Self Directed Community Support and Employment

Provider Category:

Agency

Provider Type:

Business

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Members who elect the consumer choices option may choose to purchase self-directed community supports and employment. Providers must have current liability and workers' compensation coverage as required by law.

All personnel providing self-directed community supports and employment shall:

- (1) Be at least 18 years of age.
- (2) Be able to communicate successfully with the member.
- (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
- (5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of individual-directed goods and services shall:

- (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
- (2) Submit invoices and time sheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and time sheets are received after this 30-day period.

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, Financial Management System (FMS) Provider and Iowa Department of Human Services are responsible for the verification of provider qualifications. The member verifies that employees hired have the skills and training needed to provide direct services. The FMS is responsible for the employer tasks such as completing employee background checks, verify employee citizenship or aliens status, and assuring wages are within the Department of Labor standards. The Department verifies the employee criminal and abuse background checks.

Frequency of Verification:

Verification of qualifications occurs at the time of initial use by a member in the CCO program

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Self Directed Community Support and Employment

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License (specify):

[Empty text box for License specification]

Certificate (specify):

[Empty text box for Certificate specification]

Other Standard (specify):

Members who elect the consumer choices option may choose to purchase self-directed community supports and employment. Providers must have current liability and workers' compensation coverage as required by law.

All personnel providing self-directed community supports and employment shall:

- (1) Be at least 18 years of age.
- (2) Be able to communicate successfully with the member.
- (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
- (5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of individual-directed goods and services shall:

- (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
- (2) Submit invoices and time sheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and time sheets are received after this 30-day period.

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, Financial Management System (FMS) Provider and Iowa Department of Human Services are responsible for the verification of provider qualifications. The member verifies that employees hired have the skills and training needed to provide direct services. The FMS is responsible for the employer tasks such as completing employee background checks, verify employee citizenship or aliens status, and assuring wages are within the Department of Labor standards. The Department verifies the employee criminal and abuse background checks.

Frequency of Verification:

Verification of qualifications occurs at the time of initial use by a member in the CCO program

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Self Directed Personal Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

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Category 2:

Sub-Category 2:

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Category 3:

Sub-Category 3:

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Service Definition (Scope):

Category 4:

Sub-Category 4:

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Self-directed personal care services are services and/or goods that provide a range of assistance in the member’s home or community that they would normally do themselves if they did not have a disability; activities of daily living and incidental activities of daily living that help the person remaining the home and in their community. This assistance may take the form of hands-on assistance (actually performing a task for a person) or cuing to prompt the participant to perform a task. Personal care may be provided on an episodic or on a continuing basis.

The member will have budget authority over self-directed personal care services. The dollar amount available for this service will be based on the needs identified on the service plan. Overlapping of services is avoided by the use of a case manager who manages all services and the entry into the ISIS system. The case manager and interdisciplinary team determine which service is necessary and authorize transportation for both HCBS and self-directed services.

Participants (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their case manager and ISB to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Self-directed personal care services need to be identified on the individual budget plan. The individual budget limit will be based on the service plan and the need for the services available to be converted. A utilization adjustment rate will be applied to the individual budget amount. Transportation costs within this service is billed separately and not included in the scope of personal care. Please see Section E-2- b ii. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services.

The services under the Intellectual Disability Waiver are limited to the additional services not otherwise covered under the state plan, including EPSDT, but consistent with the waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Self Directed Personal Care

Provider Category:

Agency

Provider Type:

Business

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Members who elect the consumer choices option may choose to purchase self directed personal care. Providers must have current liability and workers' compensation coverage as required by law.

All personnel providing self-directed community supports and employment shall:

- (1) Be at least 18 years of age.
- (2) Be able to communicate successfully with the member.
- (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
- (5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of individual-directed goods and services shall:

- (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
- (2) Submit invoices and time sheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and time sheets are received after this 30-day period.

The services under the Intellectual Disabilities Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, Financial Management System (FMS) Provider and Iowa Department of Human Services are responsible for the verification of provider qualifications. The member verifies that employees hired have the skills and training needed to provide direct services. The FMS is responsible for the employer tasks such as completing employee background checks, verify employee citizenship or aliens status, and assuring wages are within the Department of Labor standards. The Department verifies the employee criminal and abuse background checks.

Frequency of Verification:

Verification of qualifications occurs at the time of initial use by a member in the CCO program

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Supports for Participant Direction

Service Name: Self Directed Personal Care

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

AMembers who elect the consumer choices option may choose to purchase self directed personal care. Providers must have current liability and workers' compensation coverage as required by law.

All personnel providing self-directed community supports and employment shall:

- (1) Be at least 18 years of age.
- (2) Be able to communicate successfully with the member.
- (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
- (5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of individual-directed goods and services shall:

- (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
- (2) Submit invoices and time sheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and time sheets are received after this 30-day period.

The services under the Intellectual Disabilities Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, Financial Management System (FMS) Provider and Iowa Department of Human Services are responsible for the verification of provider qualifications. The member verifies that employees hired have the skills and training needed to provide direct services. The FMS is responsible for the employer tasks such as completing employee background checks, verify employee citizenship or aliens status, and assuring wages are within the Department of Labor standards. The Department verifies the employee criminal and abuse background checks.

Frequency of Verification:

Verification of qualifications occurs at the time of initial use by a member in the CCO program.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Attendant Care (CDAC) - skilled

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Consumer Directed Attendant Care skilled activities may include helping the member with any of the following skilled services while under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. This service may be provided in the private residence or assisted living. Skilled CDAC is not skilled nursing care, but is care provided by a lay person who has been trained to provide the specific service needed by the member.

The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The nurse is responsible for overseeing the care of the Medicaid member but is not the service provider. The cost of the supervision provided under state plan funding and is not provided under the waiver.

Skilled CDAC service is not duplicative of HHA or nursing. The case manager through the service plan authorization specifies the services and providers to provide waiver services and precludes duplication of services.

Covered skilled service activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, re-motivation, and behavior modification.
- (8) Colostomy care.
- (9) Care of out of control medical conditions which includes brittle diabetes, and comfort care of terminal conditions.
- (10) Post-surgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is a 15 - minute unit provided by an individual or an agency. The member's plan of care will address how the member's health care needs are being met. The case manager will monitor the plan.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	AAA subtracting Chore Providers
Agency	Home Health Agency
Agency	Home Care Provider
Agency	Community Action Agency

Provider Category	Provider Type Title
Agency	Supported Community Living Providers
Individual	Any individual who contracts with the member

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) - skilled

Provider Category:

Agency

Provider Type:

AAA subtracting Chore Providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

IAC 17—4.4(231)Area agencies on aging.
 4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements.

 For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) - skilled

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) - skilled

Provider Category:

Agency

Provider Type:

Home Care Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in Iowa Administrative Code 641-80.5(135), 641-80.6(135), and 641-80.7(135).

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) - skilled

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Community action agencies as designated in Iowa Code section 216A.93.
 216A.92 Division of community action agencies.
 1. The division of community action agencies is established. The purpose of the division of community action agencies is to strengthen, supplement, and coordinate efforts to develop the full potential of each citizen by recognizing certain community action agencies and supporting certain community-based programs delivered by community action agencies.
 2. The division shall do all of the following:
 a. Provide financial assistance for community action agencies to implement community action programs, as permitted by the community service block grant and subject to the funding made available for the program.
 b. Administer the community services block grant, the low-income energy assistance block grants, department of energy funds for weatherization, and other possible funding sources. If a political subdivision is the community action agency, the financial assistance shall be allocated to the political subdivision.
 c. Implement accountability measures for its programs and require regular reporting on the measures by the community action agencies.
 d. Issue an annual report to the governor and general assembly by July 1 of each year.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) - skilled

Provider Category:

Agency

Provider Type:

Supported Community Living Providers

Provider Qualifications

License (specify):

Certificate (specify):

Providers certified by the Department's Home and Community Based Services Quality Oversight Unit to provide Supported Community Living under the Intellectual Disability or Brain Injury Waiver as described in IAC 441 Chapters 77.37 and 77.39.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Service, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) - skilled

Provider Category:

Individual

Provider Type:

Any individual who contracts with the member

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

An individual who contracts with the member to provide attendant care service and who is:

1. At least 18 years of age, and
2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.
3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
5. All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has a founded abuse record.

For this service the department the specific standards for subcontracts or providers regarding training, age limitations, experience or education are indicated above. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Attendant Care (CDAC) - unskilled

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Consumer-directed attendant care (CDAC) services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. This service may be provided in the private residence. This service is not duplicative of Home Health Aide and is monitored by the case manager as part of inclusion in the member's plan. CDAC is not duplicative of self-directed personal care services. CDAC–unskilled is one of eight ID waiver services that may be used to create a self-directed budget amount CCO. When CDAC is authorized in the CCO budget, the case manager is responsible to assure that the service needs are being met and there is no duplication of services.

The service activities may include helping the member with any of the following non-skilled service activities:

- 1) Dressing.
- 2) Bath, shampoo, hygiene, and grooming.
- 3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- 4) Toilet assistance, including bowel, bladder, and catheter assistance.
- 5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.
- 6) Housekeeping services which are essential to the member's health care at home, includes shopping and laundry.
- 7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider.
- 8) Wound care.
- 9) Assistance needed to go to or return from a place of employment and assistance with job related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in member directed attendant care services.
- 10) Tasks such as financial management and scheduling that require cognitive or physical assistance.
- 11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

Self-directed services allows a member to manage and direct services to meet their assessed needs. The needs are identified through the authorization of a waiver service. The authorized service is converted to a monthly budget. The budget is used to purchase optional services through the CCO program. CCO services do not duplicate waiver services, but rather are designed to meet the needs of the authorized service. They are provided to meet the same need, but with CCO the service is called self-directed personal care and not CDAC - unskilled.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is 15-minutes. The member's plan of care will address how the member's health care needs are being met. The case manager will monitor the plan.

The individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget.

CDAC services, unskilled, may be authorize in a member's service plan in conjunction with other self-direction services but must not be duplicative of the amount, duration, and scope of authorized personal care services in the service plan.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care
Agency	Community Action Agency
Agency	Home Care Providers
Agency	AAA subtracting Chore Providers
Agency	Supported Community Living Providers
Agency	Assisted Living Programs
Agency	Home Health Agency
Individual	Any individual who contracts with the member

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) - unskilled

Provider Category:

Agency

Provider Type:

Adult Day Care

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) - unskilled

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Community action agencies as designated in Iowa Code section 216A.93.
 216A.92 Division of community action agencies.

1. The division of community action agencies is established. The purpose of the division of community action agencies is to strengthen, supplement, and coordinate efforts to develop the full potential of each citizen by recognizing certain community action agencies and supporting certain community-based programs delivered by community action agencies.
2. The division shall do all of the following:
 - a. Provide financial assistance for community action agencies to implement community action programs, as permitted by the community service block grant and subject to the funding made available for the program.
 - b. Administer the community services block grant, the low-income energy assistance block grants, department of energy funds for weatherization, and other possible funding sources. If a political subdivision is the community action agency, the financial assistance shall be allocated to the political subdivision.
 - c. Implement accountability measures for its programs and require regular reporting on the measures by the community action agencies.
 - d. Issue an annual report to the governor and general assembly by July 1 of each year.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) - unskilled

Provider Category:

Agency

Provider Type:

Home Care Providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in Iowa Administrative Code 641-80.5(135), 641-80.6(135), and 641-80.7(135).

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) - unskilled

Provider Category:

Agency

Provider Type:

AAA subtracting Chore Providers

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Consumer Directed Attendant Care (CDAC) - unskilled****Provider Category:**

Agency

Provider Type:

Supported Community Living Providers

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Providers certified by the Department's Home and Community Based Services Quality Oversight Unit to provide Supported Community Living under the Intellectual Disability or Brain Injury Waiver as described in IAC 441 Chapters 77.37 and 77.39.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Service, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Consumer Directed Attendant Care (CDAC) - unskilled****Provider Category:**

Agency

Provider Type:

Assisted Living Programs

Provider Qualifications**License (specify):****Certificate (specify):**

Assisted living programs that are certified by the Department of Inspections and Appeals under 481—Chapter 69.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) - unskilled

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Directed Attendant Care (CDAC) - unskilled

Provider Category:

Individual

Provider Type:

Any individual who contracts with the member

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

An individual who contracts with the member to provide attendant care service and who is:

1. At least 18 years of age, and
2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.
3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
5. All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has a founded abuse record.

For this service the department the specific standards for subcontracts or providers regarding training, age limitations, experience or education are indicated above. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home and Vehicle Modification

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle modifications are not furnished to adapt living arrangements that are owned or leased by providers of waiver services. Modifications may be made to privately owned rental properties. Home and vehicle repairs are also excluded. Purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle is not allowable.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes. Services shall be performed following prior department approval of the modification as specified in 441 - sub-rule 79.1(17) and a binding contract between the provider and the member. All contracts for home or vehicle modification shall be awarded through competitive bidding.

Home modifications will not be furnished to adapt living arrangements that are owned or leased by providers of waiver services including an assisted living facility.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is the completion of needed modifications or adaptations. HVM within the ID waiver is limited to a \$5,305.53 lifetime maximum. The member's plan of care will address how the member's health care needs are being met by the modification. Services must be authorized in the service plan by the case manager. Members may request an exception to policy to exceed the annual lifetime home and vehicle modification amount. The department reviews and prior authorizes all HVM requests, including requests to exceed the lifetime maximum. A notice of decision is issued to the member with all prior authorization reviews.

The services under the Intellectual Disability waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method *(check each that applies):*

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies):*

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Community Living Providers
Agency	Community Business
Agency	HVM Providers Enrolled under Other Waivers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home and Vehicle Modification

Provider Category:

Agency

Provider Type:

Supported Community Living Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers certified by the Department's Home and Community Based Services Quality Oversight Unit to provide Supported Community Living under the Intellectual Disability or Brain Injury Waiver as described in IAC 441 Chapters 77.37 and 77.39.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Service, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home and Vehicle Modification

Provider Category:

Agency

Provider Type:

Community Business

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Submit verification of current liability and workers compensation coverage.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home and Vehicle Modification

Provider Category:

Agency

Provider Type:

HVM Providers Enrolled under Other Waivers

Provider Qualifications

License (specify):

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Certificate (specify):

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Other Standard (specify):

<p>Providers enrolled to participate as HVM providers under the Health and Disability Waiver (formerly the Ill and Handicapped waiver) as described in IAC 441 Chapter 30:</p> <p>a. Area agencies on aging as designated in 17—4.4(231).</p> <p>b. Community action agencies as designated in Iowa Code section 216A.93.</p> <p>c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.</p> <p>d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.</p> <p>Enrolled as HVM providers under the Physical Disability Waiver as described in IAC 441 41:</p> <p>a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.</p> <p>b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.</p> <p>Enrolled to provide HVM services under the Elderly Waiver described in IAC 441 Chapter 33:</p> <p>a. Area agencies on aging as designated in 17—4.4(231).</p> <p>b. Community action agencies as designated in Iowa Code section 216A.93.</p> <p>c. Providers eligible to participate as home and vehicle modification providers under the health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.</p> <p>d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.</p> <p>Enrolled to provide HVM services under the Brain Injury Waiver as described in IAC 441 Chapter 39:</p> <p>a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.</p> <p>b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.</p>
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Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Interim Medical Monitoring and Treatment

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The IMMT service is used by members with medical needs and covers the time when state plan medical services, including EPSDT cannot be used, e.g., supervising and monitoring the member between medical interventions or treatment such as monitoring for suctioning a trach or for seizures that do not occur on a regular basis but need intervention when they occur. The services must be needed to allow the members usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver. The services under the Intellectual Disability waiver, including interim medical monitoring and treatment services, are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

a. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each members social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.
- (4) Be in need as ordered by a physician
- (5) Be monitored to assure it is not used as childcare.

b. Interim medical monitoring and treatment services may include supervision to and from school, but not the cost of the transportation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limitations.

- (1) A maximum of 48, 15 - minute units of service is available per day.
 - (2) Covered services do not include a complete nutritional regimen.
 - (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services, including EPSDT services, provided under the state plan.
 - (4) Interim medical monitoring and treatment services may be provided only in the members home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.
 - (5) The staff-to-member ratio shall not be greater than one to six.
- d. A unit of service is a 15 minute unit.

The services under the Intellectual Disabilities waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Community Living providers
Agency	child care facility
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Interim Medical Monitoring and Treatment

Provider Category:

Agency

Provider Type:

Supported Community Living providers

Provider Qualifications

License (specify):

Certificate (specify):

Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Interim Medical Monitoring and Treatment

Provider Category:

Agency

Provider Type:

child care facility

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441Chapter 110.

Verification of Provider Qualifications

Entity Responsible for Verification:

department of Humans Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Interim Medical Monitoring and Treatment

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Home health agencies certified to participate in the Medicare program.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Humans Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response or Portable Locator System

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency. The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability. The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

Provider staff are responsible for training members regarding the use of the system; the cost of this service is included in the charges for installation or monthly fee, depending upon how the provider structures their fee schedule. If necessary, case managers would also assist members in understanding how to utilize the system.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is a one time installation fee or month of service. Maximum units per state fiscal year shall be one initial installation and 12 months of service. The member's plan of care will address how the member's health care needs are met. Services must be authorized in the service plan. The Case Manager will monitor the plan.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency Response System Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Personal Emergency Response or Portable Locator System

Provider Category:

Agency

Provider Type:

Emergency Response System Providers

Provider Qualifications**License** (*specify*):
Certificate (*specify*):
Other Standard (*specify*):

Agencies which meet the conditions of participation for Emergency Response System Providers as set forth in Iowa Administrative Code 77.33(2).

- a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.
- b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.
- c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.
- d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.
- e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Community Living

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services. definitions of the components are as follows:

Personal and home skills training services are those activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

Individual advocacy services means the act or process of representing the individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

Community skills training services means activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget; plan and prepare nutritional meals; ability to use community resources such as public transportation, libraries, etc., and ability to select foods at the grocery store.
2. Socialization skills training services are those activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.
3. Communication skills training services are activities which assist a person to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

Personal and environmental support services means activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

The cost of transportation services is provided through the tiered rate fee schedule funding. Transportation services are used to conduct business errands and essential shopping, travel to and from work or day programs, and to assist the person to travel from one place to another to obtain services or carry out life's activities. Transportation, the waiver service, is not available to members accessing daily SCL services.

Treatment services means activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning.

Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.
2. Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person's functioning in response to the physical, emotional, and social environment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is:

- (1) One full calendar day when a member residing in the living unit receives on-site staff supervision for 8 or more hours per day as an average over a 30 days and the member's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision. Daily SCL services are reimbursed by a tiered rate fee schedule based on a member's assessed need.
- (2) 15 minute units when subparagraph (1) does not apply. 15 minute unit reimbursement amounts cannot exceed the fee schedule caps published in the Iowa Administrative Code 41-77.79(1)

For daily SCL, providers are reimbursed using a tiered rate fee schedule. The cost of all transportation, excluding NEMT transportation, is included in the daily SCL unit rate. The specific member support needs must be identified in the member's service plan and the provider must maintain records to support the expenditures.

The maximum number of units available per member is as follows:

- (1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.
- (2) 20,440 15 minute units are available per state fiscal year except a leap year when 20,496 15 minute units are available.
- h. The service shall be identified in the members individual comprehensive plan.
- i. Services shall not be simultaneously reimbursed with other residential services, HCBS ID respite, Medicaid or HCBS ID nursing, or Medicaid or HCBS ID home health aide services.

The individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget.

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Supported Community Living Providers
Agency	Licensed Foster Care
Agency	Foster Family Home Subcontractors

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Community Living

Provider Category:

Agency

Provider Type:

Certified Supported Community Living Providers

Provider Qualifications

License *(specify):*

[Empty text box]

Certificate (*specify*):

Providers certified by the HCBS Quality Oversight Unit to provide Supported Community Living pursuant to Iowa Administrative Code 441 - 77.37 and 77.39.

Other Standard (*specify*):

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Supported Community Living

Provider Category:

Agency

Provider Type:

Licensed Foster Care

Provider Qualifications

License (*specify*):

Providers of services meeting the definition of foster care shall also be licensed by the department according to applicable 441—Chapters 108, 112, 114, 115, and 116.

Certificate (*specify*):

[Empty text box]

Other Standard (*specify*):

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Supported Community Living

Provider Category:

Agency

Provider Type:

Foster Family Home Subcontractors

Provider Qualifications

License (*specify*):

Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Transportation services may be provided for members to conduct business errands, essential shopping, and to reduce social isolation. Whenever possible, natural supports (family, neighbors, or friends) or community agencies which can provide this service without charge are utilized. This service does not include transportation to medical services. As part to the annual person centered planning process, the member’s interdisciplinary team identifies transportation needs of the member and identifies paid or unpaid resources to meet the needs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of services is one mile or one one-way trip. The member's service plan will show how the member's health care needs are being met. Services must be authorized in the service plan. The case manager will monitor the plan.

The individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget.

Members accessing daily SCL and RBSCL services may have transportation services authorized in the member services plan. All transportation, excluding NEMT and transportation to and from school, will be provided through the daily SCL or RBSCL service.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	County Contracted Transportation Provider
Agency	Nursing Facilities
Agency	Area Agencies on Aging
Agency	Provider Contracting with NEMT
Agency	Subcontractor with Area Agency on Aging
Agency	Regional Transit Agencies
Agency	Supported Community Living Providers

Provider Category	Provider Type Title
Agency	Commuity Action Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

County Contracted Transportation Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Transportation providers that contract with county governments.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Nursing Facilities

Provider Qualifications

License (specify):

Licensed and inspected under Iowa Code Chapter 135C and an enrolled Medicaid provider as described in IAC 441 Chapter 81.

Certificate (specify):

[Empty text box]

Other Standard (*specify*):

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency

Provider Type:

Area Agencies on Aging

Provider Qualifications

License (*specify*):

[Empty text box]

Certificate (*specify*):

[Empty text box]

Other Standard (*specify*):

Area Agencies on Aging as designated by the Department on Aging in 17—4.4(231).

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Provider Contracting with NEMT

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Transportation providers contracting with the nonemergency medical transportation contractor.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Subcontractor with Area Agency on Aging

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency

Provider Type:

Regional Transit Agencies

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

As designated by the Iowa Department of Transportation in the Code of Iowa 28M.

28M.1 Regional transit district defined.

“Regional transit district” means a public transit district created by agreement pursuant to chapter 28E by one or more counties and participating cities to provide support for transportation of passengers by one or more public transit systems which may be designated as a public transit system under chapter 324A.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education beyond those implemented by the contracting agency or provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Supported Community Living Providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers certified by the HCBS Quality Oversight Unit to provide supported community living under the ID and BI Waiver pursuant to Iowa Administrative Code 441 - 77.37 and 77.39.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

FFS

Case managers or community based case managers provide case management services for members enrolled in the State's §1915(c) Intellectual Disability Waiver. Services are reimbursed through an administrative function of DHS.

All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned.

MCO

MCO community-based case managers provide case management services to all members receiving HCBS. MCOs ensure ease of access and responsiveness for each member to their community-based case manager during regular business hours and, at a minimum, the community-based case manager contacts members at least monthly, either in person or by phone, with an interval of at least fourteen calendar days between contacts.

MCO community-based case managers provide case management services to all members receiving HCBS. MCOs ensure ease of access and responsiveness for each member to their community-based case manager during regular business hours and, at a minimum, the community-based case manager or integrated health home care coordinator contacts members at least monthly, either in person or by phone, with an interval of at least fourteen calendar days between contacts.

All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned. MCOs are contractually required to ensure the delivery of services in a conflict free manner consistent with Balancing Incentive Program requirements. DHS approves and monitors all MCO policies and procedures to ensure compliance.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

1. For purposes of this section and section 249A.30 unless the context otherwise requires:
 - a. "Member" means an individual approved by the department to receive services under a waiver.
 - b. "Provider" means an agency certified by the department to provide services under a waiver.
 - c. "Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2. If a person is being considered by a provider for employment involving direct responsibility for a member (individual approved by the department to receive services under a waiver) or with access to a member when the member is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department [(Department of Human Services)] shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the criminal background checks. The provider agency is responsible for completing the required waiver to perform the criminal background check and submitting to the Department of Public Safety who conducts the check. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of criminal background checks are available to the Department upon request. The IME will assure that criminal background checks have been completed through quality improvement activities on a random sampling of providers, focused onsite reviews and during the full on-site reviews conducted every 5 years. During each of these review processes, the HCBS Quality Oversight unit reviews the provider's quality data collected by the provider to measure compliance with the criminal background checks. The HCBS Quality oversight unit also reviews a random sample of personnel files to verify the background checks are present in the file and reflects the provider's quality review.

The State HCBS Quality Oversight Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. There are four types of provider site visits where agency personnel records are reviewed; periodic, certification, focused and targeted. At a minimum all providers have a periodic review conducted every five years. Providers of supported community living, and respite services require a certification review that is conducted every one to three years, depending on the results of the review. Focused reviews occurs annually for a select group of providers randomly selected to review a quality topic selected by the Department. Targeted reviews are conducted as needed based on complaints received by the Department or specific provider quality concerns identified.

Criminal history and abuse registry screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. DHS also completes any evaluation needed for screenings returned with records or charges. Background checks only include Iowa unless the applicant is a resident of another state providing services in Iowa.

MCOs are contractually required to assure that all persons, whether they are employees, agents, subcontractors, or anyone acting for or on behalf of the MCO, are properly licensed, certified, or accredited as required under applicable state law and the Iowa Administrative Code. The Contractor shall provide standards for service providers who are not otherwise licensed, certified, or accredited under state law or the Iowa Administrative Code.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

1. For purposes of this section and section 249A.30 unless the context otherwise requires:
 - a. "Member" means an individual approved by the department to receive services under a waiver.
 - b. "Provider" means an agency certified by the department to provide services under a waiver.
 - c. "Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2. If a person is being considered by a provider for employment involving direct responsibility for a member (individual approved by the department to receive services under a waiver) or with access to a member when the member is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

Individual Consumer Directed Attendant Care (CDAC) is the only service that allows individuals to be providers. All other services must be provided by agency providers. Individual CDAC providers have child and dependent adult abuse background checks completed by the IME Provider Services prior to enrollment as a Medicaid provider.

All employees that provide direct services under the Consumer Choices Option under this waiver are required to complete child and dependent adult abuse background checks prior to employment with a member. The Fiscal Management provider completes the child and dependent adult abuse background checks and the employee will not pay for any services to the member prior to the completion of the checks.

The Iowa Department of Human Services maintains the Central Abuse Registry. All child and dependent adult abuse checks are conducted by the DHS unit responsible for the intake, investigation, and finding of child and dependent adult abuse. The provider agency is responsible for completing the required abuse screening form and submitting it to DHS to conduct the screening. Providers are required to complete the child and dependent adult abuse background checks of all staff that provides direct services to waiver members prior to employment. Providers are required to have written policies and procedures for the screening of personnel for child and dependent adult abuse checks prior to employment. As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the child and dependent adult abuse checks. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of child and dependent adult abuse checks are available to the Department upon request. The Department will assure that the child and dependent adult abuse checks have been completed through the Department's quality

improvement activities of random sampling of providers, focused onsite reviews, initial certification and periodic reviews and during the full on-site reviews conducted every 5 years.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. Screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. DHS also completes any evaluation needed for screenings returned with records or charges. MCOs are also required to ensure that all required screening is conducted for providers who are not employees of a provider agency or licensed/accredited by a board that conducts background checks (i.e., non-agency affiliated self-direction service providers). DHS retains final authority to determine if an employee may work in a particular program.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

A person who is legally responsible for a member may provide services to an adult waiver member. This applies to guardians of their adult children or of other adults, age 18 or older, for whom they have been legally appointed as the guardian. Parents and guardians of members age 17 and younger may not be paid providers of service. The person who is legally responsible for an adult member may be a Consumer Directed Attendant Care (CDAC) provider or an employee under the Consumer Choices Option (CCO) program. When the legally responsible person is the CDAC or CCO provider, the service planning team determines the need for and the types of activities to be provided by the legally responsible person. This includes reviewing if the needed services are “extraordinary.” Any services which are activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and are not necessary to assure the health and welfare of the member and to avoid institutionalization would not be considered extraordinary. If the guardian is an employee through CDAC or CCO, the guardian must have the skills needed to provide the services to the member. In many situations, the member requests the guardian to provide services, as the guardian knows the member and their needs best. In other circumstances, there are no other qualified providers available when the service is needed or a lack of staff in the area to provide the service.

Through the person-centered planning process, the comprehensive service plan is developed. If the member has a guardian who is also their service provider, the care plan will address how the DHS case manager or MCO community based case manager will oversee the service provision to ensure care is delivered in the best interest of the member.

The rate of pay and the care provided by the legally responsible person is identified and authorized in the member’s plan of care that is authorized and monitored by a DHS case manager or MCO community based case manager. Service plans are monitored to assure that authorized services are received. For fee-for-service members, the State completes post utilization audits on waiver providers verifying that services rendered match the service plan and claim process. This applies to individual CDAC providers. In addition, information on paid claims for fee-for-service members are available in ISIS for review. The ISIS system compares the submitted claims to the services authorized in the plan of care prior to payment. The claim will not be paid if there is a discrepancy between the amount billed and the rate of pay authorized in the plan. MCOs are responsible for ensuring the provision of services by a legally responsible individual is in the best interest of the member and that payments are made only for services rendered. All representatives must participate in a training program prior to assuming self-direction, and MCOs provide ongoing training upon request and/or if it is determined a representative needs additional training. MCOs monitor the quality of service delivery and the health, safety and welfare of members participating in self-direction, including implementation of the back-up plan. If problems are identified, a self-assessment is completed to determine what additional supports, if any, could be made available. MCOs must ensure payments are made only for services rendered through the development and implementation of a contractually required program integrity plan. The DHS maintains oversight of the MCO program integrity plans and responsibility for overall quality monitoring and oversight.

The parent of a minor child, the spouse or a legal representative of a member may not be a paid provider of service to the member. Per to 441 Iowa Administrative Code 441-79.9(7):

“a. Except as provided in paragraph 79.9(7)‘b,’ medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)‘a,’ medical assistance funds are not incorrectly paid when an individual who serves as a member’s legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013.

For purposes of this paragraph, “legal representative” means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.”

Self-directed

Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

A member's relative or legal representative may provide services to a member. Payments may be made to any relative who is not the parent of a minor child, a spouse, or in some circumstances, a legal representative of the member and meets the minimum age requirements for service provision. Legal representative means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member. Legal representatives may be paid providers for members age 18 and over for whom they act as the legal representative. A legal representative may not be paid to provide services to their spouse or minor children. The legal representative may be an Individual CDAC provider, a participant under the CCO program, or an employee hired by a provider agency. When the legal representative is the CDAC or CCO provider, the case manager or community-based case manager and interdisciplinary team determine the need for and the types of activities provided by the legal representative. If the legal representative is an employee of an enrolled provider agency, they may be paid by the enrolled provider as an employee of the provider. Medicaid payments are being made to the enrolled provider and not directly to the legal representative as is done with CDAC and CCO employees. The provider must assure the legal representative has the skills needed to provide the services to the member. It is the responsibility of the enrolled provider to recruit, train, and supervise the legal representative same as all employees.

Whenever a legal representative acts as a provider of consumer-directed attendant care, the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event. In many situations, the member requests the legal representative provide services, as the legal representative may know the member and their needs best. In other circumstances, there are no other qualified providers available when the service is needed or a lack of staff in the area to provide the service. In these cases, the legal representative must have the skills needed to meet the needs of the member

The rate of pay and the care provided by the legally responsible person is identified and authorized in the member's service plan that is authorized and monitored by the member's case manager or community-based case manager.

The DHS case manager or community-based case manager are responsible to monitor service plans and assure the services authorized in the member's plan are received. In addition, information on paid claims of fee-for-service members is available in ISIS for review. The ISIS System compares the submitted claim to the services authorized in the service plan prior to payment. The claim will not be paid if there is a discrepancy between the amount billed and the rate authorized in the plan. The state also completes post utilization audits on waiver providers verifying that services rendered match the service plan and claim process. This applies to individual CDAC providers and provider agencies. MCOs are required to adhere to all state policies, procedures and regulations regarding payment to legal guardians, as outlined in this section.

Per to 441 Iowa Administrative Code 79.9(7):

“a. Except as provided in paragraph 79.9(7)‘b,’ medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)‘a,’ medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013.

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Iowa Medicaid providers will be responsible for providing services to fee-for-service members. The Iowa Medicaid Provider Services Department markets provider enrollment for Iowa Medicaid. Potential providers may access an application on line through the website or by calling the provider services' phone number. The IME Provider Services Unit must respond in writing within five working days once a provider enrollment application is received, and must either accept the enrollment application and approve the provider as a Medicaid provider or request more information. In addition, waiver quality assurance staff and waiver program managers, as well as case managers and community based case managers, market to qualified providers to enroll in Medicaid.

MCOs are responsible for oversight of their provider networks. The State retains authority for development of the performance standards, and for review and approval of any disenrollment recommendations.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

QP-a1: IME will measure the number of newly enrolled licensed or certified waiver provider enrollment applications verified against the appropriate licensing or certification entity. Numerator = # of newly enrolled waiver providers verified against appropriate licensing or certification entity prior to providing services; Denominator = # of newly enrolled licensed or certified waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Encounter data, claims data and enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted entity"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

QP-a2: The IME will measure the number of licensed or certified waiver provider re-enrollments verified against the appropriate licensing and/or certification entity. Numerator = # of waiver provider re-enrollments verified against appropriate licensing and or certification entity prior to providing services Denominator = # of licensed or certified waiver provider re-enrollments.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Re-enrollment information out of ISIS. All MCO HCBS providers must be re-enrolled as verified by the IME Provider Services Unit every five years.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify:	Annually	Stratified Describe Group:

<input type="text" value="contract entity"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="Contracted entity"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

QP-b1: The IME shall determine the number and percent of CDAC providers that met waiver requirements prior to direct service delivery. Numerator = # of CDAC providers who met waiver requirements prior to service delivery; Denominator = # of CDAC enrolled providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted Entity"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

QP-b2: The IME shall determine the number and percent of Consumer Choice Option (CCO) providers that met waiver requirements prior to direct service delivery. Numerator = number of CCO providers who met waiver requirements prior to service delivery; Denominator = number of CCO enrolled providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Financial Management Services (FMS) provider data collection

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>

Other Specify: <input type="text" value="FMS Provider"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

QP-b3: The IME shall determine the number and percent of non-licensed/noncertified providers that met waiver requirements prior to direct service delivery. Numerator = # of non-licensed/noncertified providers who met waiver requirements prior to service delivery; Denominator = # of non-licensed/noncertified enrolled providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Enrollment records, Individualized Services Information System (ISIS), claims.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted entity"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

QP-c1: The IME will measure the total number and percent of providers, specific by waiver, that meet training requirements as outlined in State regulations. Numerator = # of reviewed HCBS providers which did not have a corrective action plan issued related to training; Denominator = # of HCBS waiver providers that had a certification or periodic quality assurance review.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Provider's evidence of staff training and provider training policies. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted Entity"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input style="width: 100%; height: 20px;" type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

If it is discovered by Provider Services Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, the provider is required to correct deficiency prior to enrollment or reenrollment approval. Until the provider make these corrections, they are ineligible to provide services to waiver members. All MCO providers must be enrolled as verified by IME Provider Services, so if the provider is no longer enrolled by the IME then that provider is no longer eligible to enroll with an MCO.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/> Contracted entity and MCO	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

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Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Information about the HCB Settings requirements is referenced Attachment #2 HCBS Settings. CMS approval of the initial statewide transition plan was granted on August 10, 2016.
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Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Service Plan

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Service planning responsibilities for FFS members in the ID Waiver is completed by DHS Targeted Cases Management. DHS TCM is an arm of the DHS Mental Health and Disability Services. DHS TCM is CARF certified for case management. DHS targeted case managers (TCM) must be licensed social workers.

TCM qualifications include: graduation from an accredited four-year college or university; or the equivalent of four years of full-time technical work experience involving direct contact with people in overcoming their social, economic, psychological, or health problems; or an equivalent combination of education and experience substituting the equivalent of one year of full-time qualifying work experience for one year (thirty semester or equivalent hours) of the required education to a maximum substitution of four years.

In addition, DHS TCMs may be required to have the following specified experience in the following areas if they are specifically working with these populations:

- Developmental disabilities: a minimum of one-year full-time (or equivalent part-time) experience in delivering or coordinating services for persons with developmental disabilities (i.e., severe, chronic mental or physical impairments). Positions that meet the intellectual disability background noted above will normally meet this selective area too. Experience in providing services and treatment to autistic children or persons with epilepsy or cerebral palsy will also qualify.

- Intellectual disability: a minimum of one year of full-time (or equivalent part-time) experience in delivering or coordinating services for persons with significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior manifested during the developmental period.

MCO

MCO community-based case managers develop service plans for members receiving HCBS waiver services. MCOs community-based case managers are required to meet the same DHS TCM qualifications, requirements, and be accredited as specified in 441 Iowa Administrative Code Chapter 24 as listed above in this section.

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Information related to waiver services and general waiver descriptions are initially made available following receipt of a waiver application. Service plans are then developed with the member and an interdisciplinary team, regardless of delivery system. Teams often consist of the member and, if appropriate, their representative; case manager or community-based case manager; service providers; and other supporting persons selected by the member. During service plan development, the member and/or their representative is strongly encouraged to engage in an informed choice of services, and is offered a choice of institutional or HCBS. Planning is timely, occurs when convenient for the member, and is intended to reflect the member's cultural considerations. If the member chooses to self-direct services, an Independent Support Broker is provided to assist with budgeting and employer functions.

The IME Member Services Unit remains available at all times, during normal business hours, to answer questions and offer support to all Medicaid beneficiaries. The IME MSU remains available to answer questions and offer support. Further, the MSU distributes a quarterly newsletter in effort to continually educate participants about services and supports that are available but may not have been identified during the service plan development process.

The fee-for-service person-centered planning processes must:

- Include people chosen by the member;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and
- Record the alternative home and community-based settings that were considered by the member.

MCOs are contractually required to provide supports and information that encourage members to direct, and be actively engaged in, the service plan development process, and to ensure that members have the authority to determine who is included in the process. Specifically, MCO person-centered planning processes must:

- Include people chosen by the member;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the member and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and
- Record the alternative home and community-based settings that were considered by the member.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-

centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

For fee-for-service members, service plans are developed by the member; DHS case manager and an interdisciplinary team. Planning meetings are scheduled at times and locations convenient for the member. The service plan must be completed prior to services being delivered and annually thereafter, or whenever there is a significant change in the member's situation or condition. The case manager receives the assessment and level of care determination from the IME Medical Services Unit. A summary of the assessment becomes part of the service plan. The case manager uses information gathered from the assessment and then works with the member to identify individual and family strengths, needs, capacities, preferences and desired outcomes and health status and risk factors. This is used to identify the scope of services needed.

Note: For both FFS and managed care enrollees, the SIS is used to assess members accessing the ID waiver. The SIS is a valid and reliable assessment tool specifically designed to measure the level, amount and intensity of service need for people with intellectual disabilities to lead normal, independent, and quality lives in society. SIS measures the member's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. The SIS was designed to be part of person-centered planning processes that help all members identify their unique preferences, skills, and life goals. The SIS measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The Scale ranks each activity according to frequency, amount, and type of support need of the member. Additionally, the behavioral and medical section of the SIS rates exceptional medical and behavioral support needs. Ratings range from 1, or no support, to 2, or extensive support needed. Finally, a Supports Intensity Level is determined based on the total support needs index, which is a standard score generated from scores on all the items tested by the Scale. This information is used by the member, case manager, and interdisciplinary team to identify member strengths, capacities, preferences that is used to develop supports and services.

The case manager informs the member of all available non-Medicaid and Medicaid services including waiver services. There are waiver informational brochures available to share with members and their parents/guardians. Information is also available on the IME and MCO websites. The brochures include information on eligibility, service descriptions, and the application process. Once a member begins the enrollment process and has a case manager or community-based case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a member's plan of care.

The case manager will also discuss with the member the self-direction option and give the member the option of self-directing services available. The member and the interdisciplinary team choose services and supports that meet the member's needs and preferences, which become part of the service plan. Service plans must:

- Reflect that the setting in which the member resides is chosen by the member;
- Reflect the member's strengths and preferences;
- Reflect the clinical and support needs as identified through the needs assessment;
- Include individually identified goals and desired outcomes which are observable and measurable;
- Include the interventions and supports needed to meet member's goals and incremental action steps as appropriate;
- Reflect the services and supports, both paid and unpaid, that will assist the member to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
- Include the identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
- Include a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications;
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Include a plan for emergencies;
- Be understandable to the member receiving services and supports, and the individuals important in supporting the member;
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the member and other people involved in the plan;
- Indicate if the member has elected to self-direct services and, as applicable, which services the member elects to self-

direct; and

-Prevent the provision of unnecessary or inappropriate services and supports.

The case manager will be responsible for coordination, monitoring and overseeing the implementation of the service plan including Medicaid and non-Medicaid services. If a member chooses to self-direct, the member, with the help of a case manager identifies who will be providing Independent Support Broker Services.

For MCO members, service plans are developed through a person-centered planning process led by the member, with MCO participation, and representatives included in a participatory role as needed and/or defined by the member. Planning meetings are scheduled at times and locations convenient for the member. A team is established to identify services based on the member's needs and desires, as well as availability and appropriateness of services. The team is also responsible for identifying an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or when the member's needs change. Service plans are completed prior to services being delivered, and are reevaluated at least annually, whenever there is a significant change in the member's situation or condition, or at a member's request. Risk assessments and mitigation plans are completed during the member's service plan (ISP) team meeting. The community based case manager determines a members risk through a series of questions and answers. Findings are documented in the Person Centered Treatment Plan. This form guides the community based case manager to identify member's personal preferences for risk mitigation including back-up arrangements. The community based case manager leads the ISP meeting, ensuring that there is a back-up arrangement for each service identified. The member, ISP team, and ancillary providers receive a copy of the plan.

In accordance with 42 CFR 441.301 and 441 Iowa Administrative Code Chapters 90.5(1)b and 83, MCOs must ensure the service plan reflects the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan must reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports. The service planning process must address the full array of medical and non-medical services and supports provided by the MCO and available in the community to ensure the maximum degree of integration and the best possible health outcomes and member satisfaction. Services plans must:

- Reflect that the setting in which the member resides is chosen by the member;
- Reflect the member's strengths and preferences;
- Reflect the clinical and support needs as identified through the needs assessment;
- Include individually identified goals and desired outcomes which are observable and measurable;
- Include the interventions and supports needed to meet members' goals and incremental action steps as appropriate;
- Reflect the services and supports, both paid and unpaid, that will assist the member to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
- Include the identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
- Include a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications;
- Reflect risk factors and measures in place to minimize them, including individualized back- up plans and strategies when needed;
- Include a plan for emergencies;
- Be understandable to the member receiving services and supports, and the individuals important in supporting him or her;
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the member and other people involved in the plan;
- Indicate if the member has elected to self-direct services and, as applicable, which services the member elects to self-direct; and
- Prevent the provision of unnecessary or inappropriate services and supports.

Appendix D: Participant-Centered Planning and Service Delivery

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the evaluation/reevaluation of level of care, risks are assessed for FFS members by a case manager and for MCO members by their respective MCO, using the assessment tools designated in B-6e. The assessment becomes part of the service plan and any risks are addressed as part of the service plan development process. The comprehensive service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. In addition, providers of applicable services shall provide for emergency backup staff. All service plans must include a plan for emergencies and identification of the supports available to the member in an emergency.

Emergencies are those situations for which no approved individual program plan exists and which, if not addressed, may result in injury or harm to the member or other persons or significant amounts of property damage.

Personal Emergency Response and Portable Locator Services are available under the waiver and it is encouraged that this service be used as part of emergency backup plan. Other providers may be listed on the service plan as source of back up as well. All members choosing the self-direction option will sign an individual risk agreement that permits the member to acknowledge and accept certain responsibilities for addressing risks.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

While information about qualified and accessible providers is available to members through the IME website, MCO website, and/or MCO Member Services call center, the case manager or community-based case manager first identifies providers to the member and their interdisciplinary team during the person-centered service planning process. Members are encouraged to meet with available providers before making a selection, and members are not restricted to choosing providers within their community. If an MCO is unable to provide services to a particular member using contract providers, the MCO is required to adequately and timely cover these services for that member using non-contract providers, for as long as the MCO's provider network is unable to provide them.

The MCOs are responsible for authorizing services for out-of-network care when they do not have an in-network provider available within the contractually required time, distance and appointment availability standards. The MCO is responsible for assisting the member in locating an out-of-network provider, authorizing the service and assisting the member in accessing the service. The MCO will also assist with assuring continuity of care when an in-network provider becomes available. To ensure robust provider networks for members to choose from, MCOs are not permitted to close provider networks until adequacy is fully demonstrated to, and approved by, the State. Further, members will be permitted to change MCOs in the event that their chosen provider does not ultimately contract with their MCO. Finally, MCOs are required to submit to the State on a regular basis provider network reports including, but not limited to network geo-access reports, 24- hour availability audit reports, provider-credentialing reports, subcontractor compliance summary reports, and provider helpline performance reports.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DHS has developed a computer program named the Individualized Services Information System (ISIS) to support HCBS programs. This system assists DHS with tracking information, monitoring, and approving service plans for fee-for-service participants. (Refer to appendix A and H for ISIS system processes.) On a monthly basis, the IME Medical Services Unit conducts service plan reviews. The selection size for the waiver has a 95% confidence level. This info is reported to CMS as part of Iowa's performance measures. ISIS will only be utilized for fee-for-service members and quality data for managed care participants will be provided by the MCOs.

The State retains oversight of the MCO service plan process through a variety of monitoring and oversight strategies as described in Appendix D – Quality Improvement: Service Plan section. On a monthly basis, each managed care organization conducts service plan reviews. The selection size for the waiver requires a 95% confidence level. The monthly info gathered by the MCOs is reported to the IME managed care Unit on a quarterly basis for review. The IME reviews the MCO service plan information and reports to CMS as part of Iowa's performance measures.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

DHS case managers maintain fee-for-service participant service plans. MCO community-based case managers maintain MCO member service plans.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

FFS

The case managers are responsible for monitoring the implementation of the service plan and the health and welfare of fee-for-service members, including:

- Monitoring service utilization.
- Making at least one contact per month with the member, the member's legal representative, the member's family, service providers, or another person, as necessary to develop or monitor the treatment plan.
- Make a face-to-face contact with the member at least once every three months.
- Participation in the development and approval of the service plan in coordination with the interdisciplinary team at least annually or as needs change. If services have not been meeting member needs, the plan is changed to meet those needs. The effectiveness of the emergency backup plan is also addressed as the service plan is developed.

The member is encouraged during the time of the service plan development to call the case manager if there are any problems with either Medicaid or non-Medicaid services. The case manager will then follow up to solve any problems.

Monitoring service utilization includes verifying that:

- The member used the waiver service at least once a calendar quarter.
- The services were provided in accordance with the plan.
- The member is receiving the level of service needed.

The ISIS system is also used to assist with tracking information, monitoring services, and assuring services were provided to fee-for-service members. If the member is not receiving services according to the plan or not receiving the services needed, the member and other interdisciplinary team members and providers are contacted immediately.

The HCBS Specialists (of the HCBS Quality Oversight Unit) monitor the how member health and welfare is safeguarded, the degree of service plan implementation; and the degree of interdisciplinary team involvement of the case manager during the HCBS Quality Assurance review. Members are asked about their choice of provider, whether or not the services are meeting their needs, whether staff and care coordinators are respecting their choice and dignity, if they are satisfied with their services and providers, or whether they feel safe where they receive services and live.

The HCBS Specialists also review the effectiveness of emergency back-up and crisis plans. These components are monitored through quality oversight reviews of providers, member satisfaction surveys, complaint investigation, and critical incident report follow-up. All providers are reviewed at least once over a five-year cycle and members are surveyed at a 95% confidence level. Information about monitoring results are compiled by the HCBS Quality Assurance and Technical Assistance Unit on a quarterly basis. This information is used to make recommendations for improvements and training.

The IME MSU also conducts quality assurance reviews of member service plans at a 95% confidence level. These reviews focus on the plan development, implementation, monitoring, and documentation that is completed by the case manager, CBCM, or health home coordinator. All service plans reviewed are assessed for member participation, whether the member needs are accurately identified and addressed, the effectiveness of risk assessments and crisis plans, member access to waiver and non-waiver services, as well as coordination across providers to best serve the member's needs. Information about monitoring results are compiled by the IME MSU on a quarterly basis. This information is used to make recommendations for improvements and training.

MCO

MCOs are responsible for monitoring the implementation of the service plan, including access to waiver and non-waiver services, the quality of service delivery, and the health, safety and welfare of members and choice of service providers. After the initiation of services identified in a member's service plan, MCOs monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan. At minimum, the care coordinator must contact members within five business days of scheduled initiation of services to confirm that services are being provided and that member's needs are being met. At a minimum, the community-based case manager shall contact 1915(c) HCBS waiver members at least monthly either in person or by telephone with an interval of at least fourteen (14) calendar days between contacts. Members shall be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least sixty (60) days between visits.

MCOs also identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively. If problems are identified, MCOs complete a self-assessment to determine what additional supports, if any, could be made available to assist the member. MCOs must develop methods for prompt follow-up and remediation of

identified problems; policies and procedures regarding required timeframes for follow-up and remediation must be submitted to DHS for review and approval. Finally, any changes to a member's risk are identified through an update to the member's risk agreement. MCOs must report on monitoring results to the State.

In the event of non-compliance with service plan timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues.

If the MCO fails to develop a plan of care for HCBS waiver enrollees within the timeframe mutually agreed upon between the MCO and the Agency in the course of Contract negotiations the MCO will be assessed a noncompliance fee of \$315 per occurrence.

DHS case managers maintain fee-for-service participant service plans. MCO community-based case managers maintain MCO member service plans. Service plans are maintained for a minimum of five years post service.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-a: The IME shall measure the number and percent of service plans that accurately reflect the member's assessed needs. The assessed needs must include, at a minimum, personal goals, health risks, and safety risks. Numerator = # of service plans that address all member assessed needs including health and safety risks, and personal goals. Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

person-centered plans and the results of the department approved assessment

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> +/- 5% with 95% confidence level </div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Contracted Entity including MCO </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%) </div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. **Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-c1: The IME will measure the number and percent of service plans which were revised when warranted by a change in the member’s needs. Numerator = # of service plans updated or revised when warranted by changes to the member’s needs. Denominator = # of reviewed service plans that indicate a change in member's needs.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

person-centered plans and the results of the department approved assessment

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">+/- 5% with 95% confidence level</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">Contracted Entity including MCO</div>	Annually	Stratified Describe Group:

		IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	<input type="text"/>

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

Performance Measure:

SP-c2: The IME will measure the number and percent of service plans which are updated on or before the member's annual due date. Numerator = # of service plans updated prior to due date; Denominator = # of service plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

person-centered plans and the results of the department approved assessment

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> +/- 5% with 95% confidence level </div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Medicaid contracted entity including MCO </div>	Annually	Stratified Describe Group:

		IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	<input type="text"/>

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-d1: TThe IME will measure the number and percent of members' service plans that identify type, scope & frequency of all services authorized in the service plan
Numerator: # members service plans that identify type, scope and frequency of all services authorized in the service plan; **Denominator =** # of service plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Service plans are requested from the case managers, with service provision documentation requested from providers

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">+/- 5% with 95% confidence level</div>
Other	Annually	Stratified

<p>Specify:</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;">Contracted Entity including MCO</div>		<p>Describe Group:</p> <div style="border: 1px solid black; padding: 5px;"> IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%) </div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p>

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<div style="border: 1px solid black; width: 100%; height: 20px;"></div>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-e2: The IME will measure the number and percentage of service plans from the HCBS QA survey review that indicated the member had a choice of providers.

Numerator: The total number of service plans reviewed which demonstrate choice of HCBS service providers; Denominator: The total number of service plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

FFS QA review of service plan stored in OnBase. MCO review services plans available through their system.

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;"> +/- 5% with 95% confidence level </div>
Other	Annually	Stratified

<p>Specify:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Medicaid contracted entity, including MCO </div>		<p>Describe Group:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%) </div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p>

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<div style="border: 1px solid black; width: 100%; height: 20px;"></div>

Performance Measure:

SP-e1: The IME will measure the number and percentage of members from the HCBS IPES who responded that they had a choice of services. Numerator = # of IPES respondents who responded that they had a choice of services; Denominator = # of IPES respondents that answered the question asking if they had a choice of services

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

FFS HCBS UNIT QA survey data and MCO IPES databases

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> +/- 5% with 95% confidence level </div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Contracted entity including MCO </div>	Annually	Stratified Describe Group:

		IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	<input type="text"/>

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The HCBS Quality Oversight Unit has identified questions and answers on the Iowa Personal Experience Survey (IPES) that demand additional attention. If member answers ‘No or I don’t know’ to an identified IPES question, a follow-up letter is sent to the case manager to ensure the member is participating in Person Centered Planning. This assures 100% follow up with the member’s case manager on all responses to the identified question. Person Centered Planning is also monitored by the HCBS QA Unit through the MCO Community Based Case Manager (CMCB) Interdisciplinary Team (IDT) Ride Along process. The QA staff participates in a random selection of IDT meetings and then follows up to ensure that the final authorized plan agrees with the plan agreed upon by the IDT.

Data and results obtained by the HCBS QIO unit are reviewed by the Quality Assurance Committee at least annually. Results from the IPES and service plan Ride Along process are reviewed for issues and trends that may require corrective actions plans development. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The Medical Services Unit utilized criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. Development of a mechanism to collect service worker remediation request response is in development.

The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. If member answers ‘ No or I don’t know’ to an identified IPES question, a follow-up letter is sent to the case manager to ensure the member is participating in Person Centered Planning. Person Centered Planning is also monitored by the HCBS QA Unit through the MCO Community Based Case Manager (CMCB) Interdisciplinary Team (IDT) Ride Along process. The QA staff participates in a random selection of IDT meetings and then follows up to ensure that the final authorized plan agrees with the plan agreed upon by the IDT. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Contracted Entities	
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Iowa offers two self-direction services the Consumer Choices Option (CCO) and Consumer Directed Attendant Care (CDAC) service.

Consumer Choices Option (CCO)

The CCO offers both employer and budget authority to the member self-directing services. Members are given information about the CCO program at the initial person centered service plan meeting and at the subsequent annual service plan meetings thereafter. At the time of service plan development and/or at the member's request, the member has the option to convert the following ID Waiver services into an individualized self-direction budget based on services that are authorized in their service plan: (1) consumer directed attendant care (unskilled); (2) day habilitation; (3) home and vehicle modification; (4) prevocational services; (5) basic individual respite care; (6) supported community living; (7) supported employment; and (8) transportation.

CCO gives members control over a targeted amount of waiver dollars. Under CCO a member may convert specific waiver services that have been authorized in the member's service plan to create an individual monthly budget. Members that choose to use CCO will use the individual monthly budget to meet their assessed needs by directly hiring employees or purchase other goods and services. A member may use the following three types of self-direction services to meet their assessed needs: (1) self-directed personal care services; (2) self-directed community supports and employment; and (3) individual-directed goods and services.

CCO information is also available on the DHS website and has a dedicated CCO webpage.

Self-directed Community Supports and Employment are services that support the member in developing and maintaining life and community integration. Individual-directed goods and services are services, equipment or supplies not otherwise provided through the Medicaid State Plan that address an identified need in the member's service plan. The items or services would decrease the need for other Medicaid services, and/or promote inclusion in the community, and/or increase the member's safety in the community or home.

Members have authority over the individual authorized budget to perform the following tasks:

- contract with entities to provide services and support;
- determine the amount to be paid for services with the exception of the independent support broker and the financial management service whereas reimbursement rates are subject to the limits in 441 Iowa Administrative Code Chapter 79.1(2);
- schedule the provision for services;
- authorize payment for waiver goods and services identified in the individual budget; and
- reallocate funds among services included in the budget. Individual monthly budget development includes the costs of the FMS, ISB, and any services and supports chosen by the member as optional service components.

All members choosing CCO work with an ISB who will help them plan for their individual budget and services. The ISB works at the direction of the member and assists the member with their budget. The ISB is required to attend an ISB training prior working with members. The ISB cannot be the guardian, power of attorney, or a provider of service to the member, to avoid potential conflicts of interest. The ISB performs the following services as directed by the member or the member's representative:

- Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- Complete the required employment packet with the financial management service.
- Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- Assist the member with negotiating with entities providing services and supports if requested by the member.
- Assist the member with contracts and payment methods for services and supports if requested by the member.

- Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member."

Members will also work with a Financial Management Service (FMS) provider that will receive Medicaid funds on behalf of the member. The FMS is the employer of record and performs all of the following services:

- Receive Medicaid funds in an electronic transfer.
- Process and pay invoices for approved goods and services included in the individual budget.
- Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- Verify for the member an employee's citizenship or alien status.
- Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 - o Verifying that hourly wages comply with federal and state labor rules.
 - o Collecting and processing timecards.
 - o Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 - o Computing and processing other withholdings, as applicable.
 - o Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 - o Preparing and issuing employee payroll checks.
 - o Preparing and disbursing IRS Forms W-2 and W-3 annually.
 - o Processing federal advance earned income tax credit for eligible employees.
 - o Refunding over-collected FICA, when appropriate.
 - o Refunding over-collected FUTA, when appropriate.
- Assist the member in completing required federal, state, and local tax and insurance forms.
- Establish and manage documents and files for the member and the member's employees.
- Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- Establish a customer services complaint reporting system.
- Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- Develop a business continuity plan in the case of emergencies and natural disasters.
- Provide to the department an annual independent audit of the financial management service.
- Assist in implementing the state's quality management strategy related to the financial management service."

To determine the monthly CCO budget amount, a "cap amount" and "budget amount" are calculated by the Iowa Medicaid Enterprise (IME) for each waiver service that can be used in the CCO program. The calculations are done to assure cost neutrality of the CCO program, i.e., that using CCO will not cost more than using traditional service purchased from an enrolled HCBS service provider. Annually, the Department determines the average service cost by identifying the individual provider service costs as identified in the member service plans. The average service cost is used to determine the "cap amount" of the CCO budget. The cap amount for a service is considered what the service would cost if CCO was not being used and the service was included in the individual member service plan. The cap amount is used to ensure the member stays within the program dollar cap limits within each waiver. This includes the monthly cap on the total services by waiver, e.g., the monthly cap on the Brain Injury or Physical Disability Waivers. The waiver program cap limits are also applied to services specific cost limits, e.g., the monthly cap on

supported employment services costs. The ID Waiver does not have total services monthly cap, but does have limits on the amount of supported Employment and home and vehicle modifications that are available for use. The service specific limits are identified in the service descriptions in Appendix C.

The department also determines the percentage of services that are used, compared to what is authorized within a waiver service plan. This is done to identify the average amount of services that are authorized in a service plan but not used. The IME calculates this by comparing the amount of service that is authorized in each member service plan to the amount of the service that is billed in the MMIS system. This percentage is applied to the service cap amount to determine the CCO “budget amount”. The budget amount is the total funds available to the member in the monthly CCO budget for the member to manage.

The member may choose to set aside a certain amount of the budget each month to save towards purchasing additional goods or services they cannot buy from the normal monthly budget. A savings plan must be developed by the member, and approved by DHS prior to implementation. The good or service being saved for must be an assessed need identified in the member’s service plan.

Consumer Directed Attendant Care (CDAC)

The CDAC service began in Iowa in 1996 and was the first attempt by the State to offer self-directed services. CDAC is a self-directed service that offers the member employer authority only. There are two CDAC services—skilled and unskilled. See Appendix C for service description and provider qualifications. All CDAC providers are enrolled Medicaid providers, and may be an individual employee or an agency. There are no FMS or ISB services to support the CDAC service and the enrolled CDAC provider performs all billing through the Medicaid MMIS systems. The IME Provider Services Unit has dedicated staff available to address CDAC issues and support the Individual CDAC provider with billing. The member’s case manager is available to support the member when using CDAC services. The member is responsible for completing the CDAC agreement with the CDAC provider. The CDAC agreement identifies the personal care services that will be performed. The member is responsible for hiring, directing, and supervising the CDAC provider to assure their identified needs are being met. Members are also responsible for signing CDAC timecards to allow payment for services.

Nonskilled CDAC services are limited to help with activities such as dressing bathing, personal hygiene, toileting, meal preparation, etc. A full description of CDAC supports are listed in Appendix C.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.

Select one:

Participant: Employer Authority. As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

CCO may be provided to a member residing in their own home, with family, or in homes with less than three member living together and receiving HCBS services in the community. DHS does not allow the use of self-direction services to members living in licensed residential care facilities (RCFs).

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Self-direction training and outreach materials are available through the IME website and MCOs. Materials include information on the benefits, responsibilities, and liabilities of self-direction. A brochure about this option has been developed and includes information about the benefits, responsibilities, and liabilities. This brochure is available at all the local DHS offices, the DHS website, and has been distributed to other community agencies. The participant may also call IME Member Services and request to have the brochure mailed directly to them. All members must sign an informed consent contract and a risk agreement that permits the member to acknowledge and accept certain responsibilities for addressing risks.

The case manager or community-based case manager is required to discuss this option along with the benefits, responsibilities and liabilities at the time of the service plan development and/or any time the member's needs change. This results in information about self-direction activities being reviewed, at least annually, with the member. This option is intended to be very flexible; members can choose this option at any time. Once given information about this option, the member can immediately elect this option, or can elect to continue or start with traditional services initially and then change to self-direction at a later date.

MCOs must also provide ongoing member or representative training upon request and/or if it is determined a member needs additional training. Training programs are designed to address the following: (i) understanding the role of members and/or representatives in self-direction; (ii) selecting and terminating providers; (iii) being an employer and managing employees; (iv) conducting administrative tasks such as staff evaluations and approval of time sheets; (v) scheduling providers; and (vi) back-up planning. All MCO training and education materials are subject to review and approval by the State.

To give the member an opportunity to locate providers and supports, the service plan can reflect that traditional services will begin at the start date of the service plan and the self-directed services and supports will begin at a later date. This does not require a change in the service plan. Members can elect self-direction and then elect to go back to traditional services at any time. The case manager or community-based case manager is responsible for informing the member of their rights and responsibilities. All self-directed services and supports must begin on the first of a month.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Services may be self-directed by a non-legal representative freely chosen by an adult member. The policies described in this section apply to both the fee-for-service and managed care delivery systems. If the member selects a non-legal representative, the representative cannot be a paid provider of services and must be eighteen years or age or older. The member and the representative must sign a consent form designating who they have chosen as their representative and what responsibilities the representative will have. The choice must be documented in the member’s file and provided to the member and their representative. At a minimum, the representative’s responsibilities include ensuring decisions made do not jeopardize the health and welfare of the member and ensuring decisions made do not financially exploit the member.

The IME uses a quality assurance process to interview members in order to determine whether or not the representative has been working in their best interest. The interviews are completed primarily by telephone and may be completed in-person if requested. The interviews are conducted as an ongoing QA activity and are used to ensure that a member's needs are met and that services are provided. QA interviews are completed monthly with a randomly selected representative sample of members. The interview sample selection size assures a 95% confidence level in the results of the interviews.

In addition, the Independent Support Broker provides monitoring of health and safety. The member’s case manager or community based case manager is responsible to assess individual needs and monitor service delivery to assure that the member’s health and safety are being addressed. Case managers or community based case managers routinely review how services are being provided and monitor services to assure the member’s needs are being met, including how the representative is performing.

MCOs are contractually required to maintain quality assurance processes to ensure that the representative functions in the best interest of the member. These quality assurance processes are subject to DHS review and approval and include, but are not limited to, monthly member interviews, to assess whether a non-legal representative is working in the best interest of the member. DHS provides additional oversight in accordance with the HCBS quality improvement strategy.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Independent Support Broker		
Supported Community Living		
Self Directed Personal Care		
Prevocational Services		
Day Habilitation		
Home and Vehicle Modification		
Self Directed Community Support and Employment		
Individual Directed Goods and Services		
Respite		
Transportation		
Consumer Directed Attendant Care (CDAC) - unskilled		
Consumer Directed Attendant Care (CDAC) - skilled		
Supported Employment		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

Financial Management Services

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Entities providing FMS must be cooperative, not-for-profit member owned and controlled, federally insured financial institution that is and chartered by either the National Credit Union Administration or the Credit Union Division of the Iowa Department of Commerce. The FMS must successfully pass a readiness review of certification by DHS or a financial institution chartered by the Office of the Comptroller of the Currency, a Bureau of the United States Department of the Treasury, is a member of the Federal Reserve; and/or is federally insured by the Federal Deposit Corporation. Further, the entity must be enrolled as a Medicaid provider. Once enrolled and approved as a Medicaid provider, the FMS will receive Medicaid funds in an electronic transfer and will pay all service providers and employees electing the self-direction option.

MCOs are responsible for contracting with an FMS entity or entities to assist members who elect to self-direct. All MCO contracted FMS entities must meet the requirements documented in this section. Under the managed care delivery system, the FMS entity contracted with the MCO is responsible for the same functions as under the fee-for-service model.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS entities are paid a monthly fee for their services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

IME provides oversight of the FMS entities and monitors their performance yearly. Oversight is conducted through an annual self-assessment, and an on-site review completed by DHS or by a designated IME unit. As noted above, FMS entities must also be enrolled as Medicaid providers. The MCOs are required to mirror this oversight process for their FMS entities and the IME reviews for compliance and monitors outcomes.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The case manager or community-based case manager provides the ID waiver member with information and assistance with choosing the CCO program or CDAC service as part of the person centered service planning process. The case manager or community-based case manager also assists the member in locating an Individual Support Broker to assist with the planning and managing a monthly CCO budget and is responsible for monitoring the delivery of goods and services as identified in the service plan.

The CCO program issues informational letters and conducts CCO webinars as needed to provide case managers, community-based case managers and ISB’s with information on understanding and implementing the CCO program. The webinars also identify self-direction issues that have been identified through quality assurance activities. All case managers and community-based case managers are welcome to attend the webinars, which are also recorded and made available for those unable to attend.

The CDAC service began in Iowa in 1996 and was the first attempt by the State to offer self-directed services. CDAC is a self-directed service that offers the member employer authority only. There are two CDAC services—skilled and unskilled. See Appendix C for service description and provider qualifications. All CDAC providers are enrolled Medicaid providers, and may be an individual employee or an agency. There are no FMS or ISB services to support the CDAC service, and the enrolled CDAC provider performs all billing through the Medicaid MMIS systems. The member is responsible for completing the CDAC agreement with the CDAC provider. The CDAC agreement identifies the personal care services that will be performed. The member is responsible for hiring, directing, and supervising the CDAC provider to assure their identified needs are being met. Members are also responsible for signing CDAC timecards to allow payment for services.

Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Emergency Response or Portable Locator System	
Independent Support Broker	
Supported Community Living	
Self Directed Personal Care	
Prevocational Services	
Day Habilitation	
Home and Vehicle Modification	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Self Directed Community Support and Employment	
Residential Based Supported Community Living	
Individual Directed Goods and Services	
Adult Day Care	
Respite	
Financial Management Services	
Transportation	
Consumer Directed Attendant Care (CDAC) - unskilled	
Consumer Directed Attendant Care (CDAC) - skilled	
Home Health Aide Services	
Interim Medical Monitoring and Treatment	
Supported Employment	
Nursing	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Through a contract with the Iowa Medicaid Enterprise (IME) the HCBS Quality Assurance and Technical Assistance Unit provides support and assistance to service workers, case managers, health home coordinators, community-based case managers, members, providers, ISBs, and others needing information about HCBS waiver programs. This includes the self-direction program. The technical assistance provided includes developing and conducting regularly scheduled webinar trainings, developing and implementing required ISB training and answering questions from the field about the CCO program.

The Quality Assurance and Technical Assistance contract is procured through a competitive bidding process. A request for proposal is issued every three years to solicit bids. The RFP specifies the scope of work to be completed by the contractor. The RFP process also includes a pricing component to assure that the contractor is reimbursed in an amount that assures performance outcomes are achieved in a cost effective manner.

The Quality Assurance and Technical Assistance contract is managed by an IME state employee. This employee acts as the contract manager and manages the day-to-day operations of the contract to assure compliance with the performance outcomes of the contract. Contract reports are received by the IME monthly, quarterly and annually on the performance measures of the contract. Any performance issues that arise are addressed with the Quality Assurance and Technical Assistance Unit contract manager to make corrections and improve performance.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

- i. Voluntary Termination of Participant Direction.** Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Members may receive traditional waiver services, as well as services and supports under an individual budget for self-direction. Any waiver member may voluntarily discontinue the self-direction option at any time, regardless of delivery system (FFS members or MCO members). The member will continue to be eligible for services as specified in the service plan, regardless of whether they select the self-direction option. When CCO is discontinued or the CCO services are voluntarily reduced, a new service plan will be developed to authorize needed services that will be provided through an enrolled ID Waiver provider (vs. the CCO program). The case manager or community-based case manager will work with the member to ensure that a current service plan is authorized and services are in place and service continuity is maintained.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

For fee-for-service members, DHS service case managers will terminate use of the self-direction option any time there is substantial evidence of Medicaid fraud or obvious misuse of funds. Involuntary termination can also occur if the case manager is not able to verify the types of services provided and the outcome of those services. If the member and their representative are both found unable to self-direct, the member will be transitioned to regular waiver services. The member has the right to appeal any adverse action taken by the case manager to terminate self-directed services and is subject to the grievance and appeals protections outlined in Appendix F. The case manager will develop a new service plan and assure alternative services are in place to maintain service.

For MCO members, a community based case managers will terminate use of the self-direction option any time there is substantial evidence of Medicaid fraud or obvious misuse of funds. Involuntary termination can also occur if the community based case manager is not able to verify the types of services provided and the outcome of those services. If the member and their representative are both found unable to self-direct, the member will be transitioned to regular waiver services. The member has the right to appeal any adverse action taken by the community based case manager to terminate self-directed services and is subject to the grievance and appeals protections outlined in Appendix F. The community based case manager will develop a new service plan and assure alternative services are in place to maintain service.

Appendix E: Participant Direction of Services

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="2600"/>
Year 2	<input type="text"/>	<input type="text" value="2600"/>
Year 3	<input type="text"/>	<input type="text" value="2600"/>
Year 4	<input type="text"/>	<input type="text" value="2600"/>
Year 5	<input type="text"/>	<input type="text" value="2600"/>

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**
- Refer staff to agency for hiring (co-employer)**
- Select staff from worker registry**
- Hire staff common law employer**
- Verify staff qualifications**
- Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Pursuant to Iowa Code 249A.29 and Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), all providers of HCBS waiver services must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff who will provide care for a member. The State pays for the first background check of workers who provide waiver services to fee-for-service members. If a second background check is completed, it is the responsibility of the employee to pay for the background check. MCOs are responsible for the costs of investigations of workers who provide waiver services to members.

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Same as C-2-a above.

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment**Authorize payment for waiver goods and services****Review and approve provider invoices for services rendered****Other**

Specify:

--

Appendix E: Participant Direction of Services**E-2: Opportunities for Participant-Direction (3 of 6)****b. Participant - Budget Authority**

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Under the traditional service model for the ID waiver, the member chooses a service provider from a list of providers who are enrolled with Iowa Medicaid. The case manager or community based case manager and the member work together develop and authorize the needed services in the member's service plan. After service provision, the provider submits a claim to the IME where the claim is adjudicated in accordance with IME protocols.

Under the self-direction option, a member is not limited to the providers who are enrolled with Iowa Medicaid. The member is considered the employer and may choose any employee or community based business that is qualified to provide the needed service. Members create a self-directed budget to identify provider and service choices to meet their identified needs. Members determine the wages to be paid to the employee and the units of service (limited by the self-direction budget). Employee interviewing, hiring, scheduling, and firing are done by the member. Claims are submitted to the FMS for processing and payment.

Each member who chooses to self-direct their services will continue to have a traditional service plan developed that is based on the core standardized assessment and service needs of the member. If a member is authorized for services that can be included in the individual budget and they choose self-direction, the individual budget amount is determined by the amount and type of service that was authorized in the traditional service plan. The amount and type of services needed are determined through the person centered planning process and authorized in the member's service plan by the case manager or community based case manager prior to the member selecting the self-direction option.

To determine a member's CCO budget amount, the department determines the average unit cost for each service available for use in CCO based on actual unit costs of the service as billed by the enrolled Medicaid providers from the previous fiscal year plus a cost-of-living adjustment. In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department applies a utilization adjustment factor to the amount of service authorized in the member's service plan. The department computes the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent.

The individual budget rate setting methodology is stated in the 441 Iowa Administrative Code Chapter 78.41(15). In addition this information is shared during all outreach and training held throughout the State for members, families, and other advocates. The MCOs are also responsible for making the budget methodology available to members through their case managers and member communication materials.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Members, regardless of delivery system (i.e., FFS members and MCO members) will be informed of their budget amount during the development of the service plan. The budget amount is based on the amount and type of services that are converted from the member's authorized service plan. The member can then make a final decision as to whether they want the self-direction option. If a member needs an adjustment to the budget, the member can:

- Request the case manager or community based case manager to review of the current authorized service plan to identify if an increase in services is needed.
- If there is a need that goes beyond the budget amount and/or the waiver service limit, the member has the right to request an exception to policy to allow additional CCO funds be made available to the member. Approval of an exception to policy requires the review and sign off of the Director of the Department of Human Services.

Any member has the right to appeal any adverse action taken. The member is afforded the opportunity to request a fair hearing when the increased service request is denied or the amount of budget is reduced as described in F-1. MCO enrollees have the right to a State Fair Hearing after exhausting the MCO appeals process. It is the responsibility of the case manager or community case manager to inform the member of the budget amount allowed for services before the service plan is completed.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

- iv. Participant Exercise of Budget Flexibility.** *Select one:*

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

For both fee-for-service and MCO members, once the monthly budget amount has been established, the member will develop a detailed monthly budget that identifies the goods and services that will be purchased and the employees that will be hired to meet the assessed needs of the member. The budget is sent to the FMS to identify what goods and services are approved for purchase and the employees that will be submitting timecards to the FMS for payment. The member can modify services and adjust dollar amounts among line items in the individual budget without changing the member's authorized service plan as long as it does not exceed the authorized budget amount. Current monthly expenditures must also be taken into consideration when adjusting the CCO budget mid-month. The member must submit a new budget to the FMS that identifies the changes. The FMS must receive all modifications to the individual budget within the month when the changes occur and will monitor the new budget to assure the changes do not exceed the authorized budget amount. The Individual Support Broker and the FMS will both monitor to assure expenses are allowable expenses.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

When members chose self-direction they sign a consent form that explains their rights and responsibilities, including consequences for authorizing payments over the authorized budget amount.

Members are responsible to monitor their own plans, and are responsible for the consequences. One of the statements from Form 470-4289 Informed Consent and Risk Agreement states: "I understand that if I overspend my budget and no longer have funds in my Individual budget, I am personally responsible to pay my employees and to pay for my purchases."

Self-directed service utilization is monitored by the member's case manager or community based case manager quarterly to assure it continues to meet the needs of the member. At least annually and or more frequently as needed by the member. An annual service plan review is conducted to review all services that were authorized in the previous year to assure they require continued authorization. The case manager or community based case manager has access to self-directed service utilization of the member in the previous year and may reduce the amount of services if it is determined that the member was not fully using the services as authorized.

The following safeguards are in place to prevent premature depletion of participant budget:

- The case manager and member or legal representative work together to create a service plan addressing person centered needs.
- The member selects services to be self-directed. This information is included in the service plan.
- The case manager authorizes services in the service plan.
- The member or legal representative the signs service plan to indicate agreement with the plan.
- The case manager identifies the CCO budget amount and provides the amount to the member or legal representative and Independent Support Broker (ISB).
- The member and the ISB complete the CCO budget on the budget sheet, form 470-4431. The budget amount on the budget sheet cannot exceed the amount approved by the case manager in the service plan
- The member or legal representative signs the budget sheet to indicate understanding and agreement.
- The budget sheet is forwarded to the FMS prior to the month of service identified on the budget.
- The FMS staffs a call center to respond timely to member, legal representative and ISB questions about processes and remaining budget balances.
- The FMS verifies that the amount included on the budget form does not exceed the authorized budget amount.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Application Process for both FFS and MCO enrolled members:

Members are given an oral explanation of the appeals (State Fair Hearing) process during the application process by the Iowa Department of Human Services (DHS) income maintenance staff. The responsibility to explain the right to request a State Fair Hearing for choice between institutional care vs. HCBS is the responsibility of the state's Income Maintenance worker at the time of waiver application; this action is not the responsibility of the MCO.

The Department also gives members an oral explanation at the time of any contemplated adverse benefit determination. Depending on the adverse benefit determination, this could be provided by the income maintenance worker, case manager, community-based case manager, medical provider performing the level of care determination. The member is also given written notice of the following at the time of application and at the time of any department adverse benefit determination. An adverse benefit determination affects a claim for assistance in which applicants are not provided the choice of home and community based services as an alternative to institutional care and members are denied services or providers of their choice, or whose services are denied, suspended, reduced or terminated.

An adverse benefit determination notice of determination that results in members' right to appeal includes the following elements: the right to request a hearing, the procedure for requesting a hearing, the right to be represented by others at the hearing, unless otherwise specified by the statute or federal regulation, provisions for payment of legal fees by DHS; and how to obtain assistance, including the right to continue services while an appeal is pending.

All DHS application forms, notices, pamphlets and brochures contain information on the appeals process and the opportunity to request an appeal. This information is available at all of the local offices and on the DHS website. The process for filing an appeal can be found on all Notices of Decision (NOD). Procedures regarding the appeal hearing can be found on the NOD. As stated in Iowa Administrative Code, any person or group of persons may file an appeal with DHS concerning any decision, made. The member is encouraged, but not required, to make a written appeal on a standard Appeal and Request a Hearing form. Appeals may also be filed via the DHS website. If the member is unwilling to complete the form, the member would need to request the appeal in writing.

All notices are kept at all local DHS Offices or the case manager or community-based case manager's file. The member is given their appeal rights in writing, which explains their right to continue with their current services while the appeal is under consideration. Copies of all notices for a change in service are maintained in the service file. IME reviews this information during case reviews.

MANAGED CARE ORGANIZATIONS:

When an HCBS member is assigned to a specific MCO, the assigned MCO community based case manager explains the member's appeal rights through the Fair Hearing process during the initial intake process. The responsibility to explain the right to request a State Fair Hearing for choice between institutional care vs. HCBS is the responsibility of the state's Income Maintenance worker at the time of waiver application; this action is not the responsibility of the MCO.

The MCOs keep the notifications as indicated here:

Amerigroup: Notices are sent to requesting provider, member, and a copy is stored in online member medical record file.

UnitedHealthCare: Notices of adverse action (which outline a member's rights to Fair Hearing) are housed within specified documentation storage systems based on service/case type. These systems include: Linx, ECAA, and ETS.

In accordance with 42 CFR 438, an adverse benefit determination means any of the following:

- (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- (2) The reduction, suspension, or termination of a previously authorized service.
- (3) The denial, in whole or in part, of payment for a service.
- (4) The failure to provide services in a timely manner, as defined by the State.
- (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
- (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

In accordance with 42 CFR 438, an appeal means a review by an MCO of an adverse benefit determination that it has issued.

MCOs give their members written notice of all adverse benefit determinations, not only service authorization adverse benefit determinations, in accordance with state and federal rules, regulations and policies, including but not limited to 42 CFR 438. MCO enrollment materials must contain all information for appeals rights as delineated in 42 CFR 438.10, including: (A) the right to file an appeal; (B) requirements and timeframes for filing an appeal; (C) the availability of assistance in the filing process; (D) the right to request a State Fair Hearing after the MCO has made a determination of a member's internal MCO appeal which is adverse to the member. The fact that, if requested by the member, benefits that the MCO seeks to reduce or terminate will continue if the member files an appeal or requests a State fair hearing within the specified timeframe and that the member may be required to pay the cost of such services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the member.

MCOs must provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to providing interpreter services, and toll-free numbers that have adequate TTY/TTD and interpreter capability. Upon determination of the appeal, the MCO must ensure there is no delay in notification or mailing to the member and member representative the appeal decision. The MCO's appeal decision notice must describe the adverse benefit determinations taken, the reasons for the adverse benefit determination, the member's right to request a State fair hearing, process for filing a fair hearing and other information set forth in 42 CFR 438.408(e).

MCOs must maintain an expedited appeals process when the standard time for appeal could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain or regain maximum function. The MCO must also provide general and targeted education to members and providers regarding expedited appeals including when an expedited appeal is appropriate and procedures for providing written certification thereof.

The MCO's appeal process must conform to the following requirements:

- Allow members, or providers acting on the member's behalf, sixty (60) calendar days from the date of adverse benefit determination notice within which to file an appeal.
- In accordance with 42 CFR 438.402, ensure that oral requests seeking to appeal an adverse benefit determination are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.
- The MCO must dispose of expedited appeals within 72 hours after the Contractor receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c).
- In accordance with 42 CFR 438.410, if the MCO denies the request for an expedited resolution of a member's appeal, the MCO must transfer the appeal to the standard thirty (30) calendar day timeframe and give the member written notice of the denial within two (2) calendar days of the expedited appeal request. The MCO must also make a reasonable attempt to give the member prompt oral notice.
- The MCO must acknowledge receipt of each standard appeal within three (3) business days.
- The MCO must make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 CFR 438.408. If the timeframe is extended, for any extension not requested by the member, the MCO must give the member written notice of the reason for the delay.
- In accordance with 42 CFR 438.408, written notice of appeal disposition must be provided with citation of the Iowa Code and/or Iowa Administrative Code sections supporting the adverse benefit determination in non-authorization and care review letters that advise members of the right to appeal. For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice. The written notice of the resolution must include the results of the resolution and the date it was completed. For appeals not resolved wholly in favor of the member, the written notice must include the right to request a State fair hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. The MCO shall direct the member to the Agency Appeal and Request for Hearing form as an option for submitting a request for an appeal. This shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds the Contractor's adverse benefit determination.

Members enrolled with an MCO must exhaust the MCO's internal grievance processes before pursuing a State Fair Hearing. This requirement is outlined in the concurrent §1915(b) waiver, Part IV, Section E.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Each MCO operates its own internal grievance and dispute resolution processes. In accordance to 42 CFR 438.408(f), a managed care enrollee may request a State Fair Hearing only after receiving notice that the MCO is upholding the adverse benefit determination.

The policies and procedures regarding the MCO grievance and appeals system are outlined in the concurrent §1915(b) waiver, Part IV, Section E. MCO members can appeal any adverse benefit determination within 60 calendar days. An adverse benefit determination is defined as the:

- (i) denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- (ii) reduction, suspension or termination of a previously authorized service;
- (iii) denial, in whole or in part, of payment for a service;
- (iv) failure to provide services in a timely manner;
- (v) failure of the MCO to act within the required timeframes; or
- (vi) the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

MCOs must ensure that oral requests seeking to appeal an adverse benefit determination are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution. MCOs must make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 C.F.R. § 438.408. Expedited appeals must be disposed within seventy-two (72) hours unless the timeframe is extended pursuant to 42 CFR § 438.408 and 410. MCO members can also file grievances with their MCO; grievances are any written or verbal expression of dissatisfaction about any matter other than an adverse benefit determination." MCO members have the right to request a State Fair Hearing if dissatisfied with the outcome of the MCO appeals process. MCOs notify members of this right through enrollment materials and notices of adverse benefit determination, including information that the MCO grievance and appeals process is not a substitute for a Fair Hearing. MCOs must acknowledge receipt of a grievance within three (3) business days and must make a decision on grievances and provide written notice of the disposition of grievance within thirty (30) calendar days of receipt of the grievance or as expeditiously as the member's health condition requires. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 C.F.R. § 438.408.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

FEE FOR SERVICE:

IME is responsible for operation of the complaint and grievance reporting process for all fee-for-service members. In addition, the Department maintains an HCBS Quality Oversight Unit contract that is responsible for the handling of fee-for-service member complaints and grievances in regards to provision of services under this waiver.

MANAGED CARE ORGANIZATION:

IME Member Services MCO Member and MCO Liaison: Designated IME Member Services staff serves as a liaison for any MCO grievance/complaint that is reported to IME Policy staff by an MCO member or his/her advocate. IME Policy sends the pertinent details of the grievance/complaint to the MCO liaison. The IME MCO liaison communicates and coordinates with the MCO and member to grievance/complaint to resolution; and, the resolution is communicated to the IME Policy staff who received the original grievance/complaint. This process serves to support those MCO members who may be confused about the MCO grievance/complaint process to follow or members who have not been able to resolve their grievance/complaint with their MCOs.

Grievances/complaints follow the parameters and timelines in accordance with 42 CFR 438.408 and 438.410.

A grievance/complaint means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision.

MCO Grievance/Complaint System:

The MCO must provide information about its grievance/complaint system to all providers and subcontractors at the time they enter into a contract. Further, the MCO is responsible for maintenance of grievance records in accordance with 42 CFR 438.416.

The MCO must provide information about its grievance/complaint system to all members and provide reasonable assistance in completing forms and taking procedural steps. This responsibility also includes; but is not limited to, auxiliary aids and services upon request (e.g. interpreter services and toll free numbers that have TTY/TTD and interpreter capability).

The MCO member handbook must include information, consistent with 42 CFR 38.10.

The MCO must insure that individuals who make decisions on grievances have not been involved in any previous level of review or decision-making and is not a subordinate of such individual.

MCO Grievance/Complaint Process:

A member may submit an oral or written grievance at any time to the MCO. With written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. There is not a timeline for submission.

The MCO must acknowledge receipt of the grievance.

The MCO must process the grievance resolution within 30 days of the date that the grievance is received and issue a written notification to the member in accordance with 42 CFR 438.408.

The resolution may be extended by fourteen (14) days upon member request. If the member does not request an extension, the MCO must make reasonable efforts to give the member prompt oral notice of the delay; and within two (2) calendar days provide the member with a written notice of the basis for the decision to extend the timeframe. If the member does not agree with the extension, he/she may file an additional grievance to the extension.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Any fee-for-service waiver member, member's relative/guardian, agency staff, concerned citizen or other public agency staff may report a complaint regarding the care, treatment, and services provided to a member. A complaint may be submitted in writing, in person, by e-mail or by telephone. Verbal reports may require submission of a detailed written report. The complaint may be submitted to an HCBS Provider Quality Oversight Specialist, HCBS Program Manager, any IME Unit, or Bureau Chief of Long Term Care. Complaints by phone can be made to a regional HCBS Provider Quality Assurance Oversight Specialist at their local number or by calling the IME. The Bureau of Long Term Care has established a committee to review complaints. The committee will meet biweekly to review current complaints.

Once received, the HCBS Quality Oversight Unit shall initiate investigation within one business day of receipt and shall submit a findings report to the Quality Assurance Manager within 15 days of finalizing the investigation. Once approved by the Quality Assurance Manager, the findings report is provided to the complainant and the provider in question. If the complainant is a member, they are informed by the HCBS Quality Oversight Unit Incident and Complaint Specialist that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing.

MCO members must exhaust the entity's internal grievance and appeals processes before pursuing a State Fair Hearing. The policies and procedures regarding the MCO grievance and appeals system are outlined in the concurrent §1915(b) waiver, Part IV, Section E. MCO members can appeal any "action" within 60 days. An "action" is defined as the: (i) denial or limited authorization of a requested service, including the type or level of service; (ii) reduction, suspension or termination of a previously authorized service; (iii) denial, in whole or in part, of payment for a service; (iv) failure to provide services in a timely manner; or (v) failure of the MCO to act within the required timeframes set forth in 42 CFR 438.408(b). In accordance with 42 CFR 438.406, oral requests seeking an appeal are treated by the MCO as an appeal; however, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.

MCO members have the right to request a State Fair Hearing if dissatisfied with the outcome of the MCO appeals process. MCOs notify members of this right through enrollment materials and notices of action. In accordance with 42 CFR 438.406, the MCO provides the member and their representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents or records considered during the appeals process. In addition, the member and their representative have the opportunity to present evidence and allegations of fact or law in person as well as in writing. Upon determination of the appeal, the MCO must promptly notify the member and his/her representative of the appeal decision. The MCO's appeal decision notice must describe the actions taken, the reasons for the action, the member's right to request a State Fair Hearing, process for filing a Fair Hearing and other information set forth in 42 CFR 438.408(e).

MCOs must ensure that the individuals rendering decisions on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with appropriate clinical expertise in treating the member's condition or disease if the decision will be in regard to any of the following: (i) an appeal of a denial based on lack of medical necessity; (ii) a grievance regarding denial of expedited resolution of an appeal; or (iii) any grievance or appeal involving clinical issues. Appeals must be resolved by the MCO within 30 calendar days of receipt; this timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c).

MCOs must resolve appeals on an expedited basis when the standard time for appeal could seriously jeopardize the member's health or ability to maintain or regain maximum function. Such expedited appeals must be resolved within 72 hours after the MCO receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c). Standard appeals must be resolved within 30 calendar days; this timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c). If the timeframe is extended, for any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay. Within 90 calendar days of the date of notice from the MCO on the appeal decision, the member may request a State Fair Hearing.

MCO members can also file grievances with their MCO; grievances are any written or verbal expression of dissatisfaction about any matter other than an "action," as defined above. Grievances may be filed either orally or in writing; receipt is acknowledged by the MCO within 3 business days and resolved within 30 calendar days or as expeditiously as the member's health condition requires. This timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c).

MCOs are required to track all grievances and appeals in their information systems; this includes data on clinical reviews, appeals, grievances and complaints and their outcomes. MCOs are responsible for reporting on grievances and appeals to

DHS. This includes maintenance and reporting to the State the MCO member grievance and appeals logs which includes the current status of all grievances and appeals and processing timelines.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All waiver service providers, case managers, and MCO community based case managers (CBCMs), regardless of delivery system (i.e., FFS or managed care), are required to document major and minor incidents and make the incident reports and related documentation available to DHS upon request. Providers, case managers, and MCO CBCMs must also ensure cooperation in providing pertinent information regarding incidents as requested by DHS. MCOs must require that all internal staff and network providers report, respond to, and document major incidents, as well as cooperate with any investigation conducted by the MCO or outside agency, all in accordance with State requirements for reporting incidents for 1915(c) HCBS Waivers, 1915(i) Habilitation Program, PMICs, and all other incidents required for licensure of programs through the Department of Inspections and Appeals.

Per Chapter 441 Iowa Administrative Code 77.25(1), “major incidents” are defined as an occurrence involving a participant during service provision that: (1) results in a physical injury to or by the participant that requires a physician’s treatment or admission to a hospital;

(2) results in the death of any person;

(3) requires emergency mental health treatment for the participant;

(4) requires the intervention of law enforcement;

(5) requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

(6) constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or

(7) involves a participant’s location being unknown by provider staff who are assigned protective oversight.

All major incidents must be reported within 48 hours of witnessing or discovering an incident has occurred, using the IME’s Iowa Medicaid Portal Access (IMPA) System. Suspected abuse or neglect may be reported to the statewide abuse reporting hotline operated by DHS.

Child and dependent adult abuse is an inclusive definition that includes physical and sexual abuse, neglect and exploitation. Child abuse is defined in Iowa Code 232.68, and may include any of the following types of acts of willful or negligent acts or omissions:

- Any non-accidental physical injury.

- Any mental injury to a child’s intellectual or psychological capacity.

- Commission of a sexual offense with or to a child.

- Failure on the part of a person responsible for the care of a child to provide adequate food, shelter, clothing or other care necessary for the child’s health and welfare.

- Presence of an illegal drug in a child’s body as a direct act or omission of the person responsible for the care of a child or manufacturing of a dangerous substance in the presence of a child.

Dependent adult abuse is defined in Iowa Code 235B.2, and may include any of the following types of acts of willful or negligent acts or omissions:

- Physical injury or unreasonable confinement, unreasonable punishment, or assault of a dependent adult.

- Commission of a sexual offense or sexual exploitation.

- Exploitation of a dependent adult.

- Deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care or other care necessary to maintain a dependent adult’s life or health.

When a major incident occurs, provider staff must notify the member or the member’s legal guardian within 24 hours of the incident and distribute a completed incident report form as follows:

- Forward a copy to the supervisor with 24 hours of the incident.

- Send a copy of the report to the member’s case manager and the IME within 24 hours of the incident.

- File a copy of the report in a centralized location and make a notation in the member’s file.

Per Chapter 441 Iowa Administrative Code 77.25(1), “minor incidents” are defined as an occurrence involving a participant during service provision that is not a major incident and that:

(1) results in the application of basic first aid;

(2) results in bruising;

(3) results in seizure activity;

(4) results in injury to self, to others, or to property; or

(5) constitutes a prescription medication error.

Providers are not required to report minor incidents to the IME or MCO, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the member's file. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs, or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the member's file.

As part of the quality assurance policies and procedures for HCBS Waivers, all major incidents will be monitored and remediated by the HCBS Incident Reporting Specialist and HCBS specialists. On a quarterly basis, the Quality Assurance (QA) committee will review data collected on incidents and will analyze data to determine trends, problems and issues in service delivery and make recommendations of any policy changes.

MCOs are also required to develop and implement a major incident management system in accordance with DHS requirements, in addition to maintaining policies and procedures that address and respond to incidents, remediate the incidents to the individual level, report incidents to the appropriate entities per required timeframes, and track and analyze incidents.

MCOs must adhere to the State's quality improvement strategy described in each HCBS waiver and waiver-specific methods for discovery and remediation. MCOs must utilize system information to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. All MCO staff and network providers are required to:

- Report major incidents.
- Respond to major incidents.
- Document major incidents.
- Cooperate with any investigation conducted by the HCBS Quality Assurance and Technical Assistance Unit staff, MCO, or outside agency.
- Receive and provide training on major incident policies and procedures.
- Be subject to corrective action as needed to ensure provider compliance with major incident requirements.

Finally, MCOs must identify and track major incidents, and review and analyze major incidents, to identify and address quality of care and/or health and safety issues, including a regular review of the number and types of incidents and findings from investigations. This data should be used to develop strategies to reduce the occurrence of major incidents and improve the quality of care delivered to members.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information concerning protections from abuse, neglect, and exploitation is provided to applicants and members at the time of application and at the time of service plan development. During enrollment, and when any updates are made, DHS also provides to members a Medicaid Members Handbook, which contains information regarding filing a complaint or grievance. MCO written member enrollment materials also contain information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect.

In addition, information can also be found on DHS and MCO websites. The DHS website contains a “Report Abuse and Fraud” section, which describes how to report dependent adult child abuse. The same information is also available in written format in the 99 local DHS offices, and members may also call the IME Member Services call center with any questions regarding filing a complaint or grievance.

Finally, the case manager or community-based case manager is responsible for assessing a member’s risk factors annually during the reevaluation process, as well as during the quality assurance interview process and the annual IPES interview. DHS recognizes the need to provide training to members using on a more formal process. The state has developed training to ensure that case managers and community-based case managers provide this information to members at a minimum on a yearly basis.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Reporting of suspected child or adult abuse to DHS Protective Services is mandatory for all IME HCBS staff, case managers, MCO CBCMs, and HCBS providers. DHS Protective Services (PS) receives all mandatory reports of child and dependent adult abuse. If an immediate threat of physical safety is believed to exist, PS makes every effort to examine that child or dependent adult within one hour of receipt and take any lawful action necessary. If the child or dependent adult is not in danger, PS makes every effort to examine the child or dependent adult within 24 hours. PS notifies the member's case manager or community-based case manager when an investigation has been initiated to ensure they are aware of the alleged abuse, and to ensure that additional services can be added or changes can be made to the member's plan of care if needed. PS provides an evaluation report within twenty days of receipt of the report of abuse, which includes necessary actions and/or an assessment of services needed. The Central Registry of Abuse and County Attorney also receives PS reports. For both child and dependent adult abuse cases, the member and/or the family are notified of the results in writing by DHS as soon as the investigation has concluded. This applies to both individuals enrolled in fee-for-service or managed care.

If the incident is a situation that has caused, or is likely to cause a serious injury, impairment, or abuse to the member, and if PS has completed, or is in the process of conducting an investigation, the HCBS Specialist (employed by the IME HCBS Quality Oversight contractor) coordinates activities with PS to ensure the safety of the member is addressed. If PS is not investigating and immediate jeopardy remains, the member's case manager or community-based case manager is notified immediately to coordinate services, and the HCBS Specialist initiates a review within two working days of receipt of the report. If it is determined that immediate jeopardy has been removed or not present, review by the HCBS Specialist is initiated within twenty working days of receipt of report. The HCBS Specialist prepares a report of findings within thirty days of the investigation being completed and presents it to the IME, the provider, and interested stakeholders (i.e., members, guardians, etc.). These timelines apply to both individuals enrolled in fee-for-service or managed care.

The IME meets bi-weekly to review major incident reports of child and dependent adult abuse and member deaths that have been reported through the major incident reporting process. DHS reviews and requests information from the case manager, community-based case manager or HCBS Specialist for follow through and resolution of the abuse allegation and member deaths. Requests for information are forwarded to the case manager or community-based case manager to verify any needed changes and confirm that follow-up has occurred with the member (i.e., changes to a plan of care or the safety or risk plan as necessary). If additional information or actions are required of a provider, the HCBS Specialist works directly with the provider to ensure that performance issues identified in the incident report are addressed. The HCBS Specialist uses the provider's Self-Assessment as the foundation of the review to assure that accuracy in the Self-Assessment and to identify any corrective actions that may be required. The HCBS Specialist generates a report of findings within thirty days of the completion of any review requiring corrective actions.

Information requests to the case manager, community-based case manager or HCBS Specialist for follow up are tracked by the HCBS Quality Oversight Unit on a weekly basis until the situation has been resolved. DHS implemented a web-based major incident reporting system September 1, 2009, that significantly enhanced the State's ability to track and trend the discovery, remediation, and improvement of the major incident reporting process. Revisions have been made to the system based on data collection and feedback from users, further enhancing the process. Incidents are reviewed by the HCBS Quality Oversight Unit within one business day of report and forwarded to the case manager or community-based case manager as needed to coordinate any follow-up and communication with the member, provider, and/or family/legal guardian. Incidents that lead to a targeted review will initiate investigation by the HCBS Quality Oversight Unit within one business day. Findings reports are submitted to the Quality Assurance Manager within 15 days of investigation completion. Once the finding report is approved by the Quality Assurance Manager, the findings report is sent to the provider and case manager, community-based case manager, or HCBS Specialist.

MCOs are responsible for developing and implementing major incident management systems in accordance with the DHS requirements identified in Appendix G-1-b. Specifically, MCOs must maintain policies and procedures, subject to DHS review and approval, that:

- (1) address and respond to incidents;
- (2) report incidents to the appropriate entities per required timeframes; and
- (3) track and analyze incidents.

This information is utilized to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. Training must be provided to all internal staff and network providers regarding the appropriate procedures for reporting, responding to, and documenting major incidents. Network providers must provide training to

direct care staff regarding the appropriate procedures for reporting, responding to, and documenting major incidents.

Finally, if the major incident involves the report of child or dependent adult abuse, it is mandatory that this type of major incident is reported to DHS Protective Services. If the major incident does not involve child or dependent adult abuse, it will be reviewed by the MCO. The MCO will notify the member and/or the family of the results upon conclusion of the investigation, on or within 30 days.

MCOs must identify and track, review and analyze major incidents to identify and address quality of care and/or health and safety issues. MCOs must also regularly review the number and types of incidents and findings from investigations, in order to identify trends, patterns, and areas for improvement. Based on these findings, the MCO must develop and implement strategies to reduce the occurrence of major incidents and improve the quality of care delivered to members. Consistent with 441 Iowa Administrative Code 77.25 (3), the following process is followed when a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

- a. The staff member's supervisor.
- b. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to a guardian, if any, is always required.
- c. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization or for members not enrolled with a MCO, the department's bureau of long-term care either:

- a. By direct data entry into the Iowa Medicaid Provider Access System, or
- b. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

- a. The name of the member involved.
- b. The date and time the incident occurred.
- c. A description of the incident.
- d. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.
- e. The action that the provider staff took to manage the incident.
- f. The resolution of or follow-up to the incident.
- g. The date the report is made and the handwritten or electronic signature of the person making the report.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The IME has oversight for monitoring incidents that affect all waiver members. The IME HCBS Quality Oversight Unit reviews all critical incident reports as soon as they are reported to DHS. All critical incidents are tracked in a critical incident database that tracks the date of the event, the specific waiver the member is enrolled in, the provider (if applicable), and the nature of the event, and follow up provided. For other non-jeopardy incidents, a review is initiated within twenty days. The HCBS Quality Assurance and Technical Assistance Unit meets biweekly to review data tracked in the critical incident database and to decide if policy changes or additional training are needed. Data is compiled and analyzed in attempt to prevent future incidents through identification of system and provider specific training needs, and individual service plan revisions.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of

a. Use of Restraints. *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DHS policy regarding restraints is as follows, and applies to all types of restraints that may be used by waiver providers. The policy described in this section applies regardless of delivery system (i.e., FFS participants or MCO members), and MCOs are contractually obligated to adhere.

Restraints include, but are not limited to, personal, chemical, and mechanical methods used for the purpose of controlling the free movement of an member's body. Chemical restraints are most commonly used to calm a member down in moments of escalation. Other examples of restraints include, but are not limited to, holding a member down with one's hands, tying a member to a bed, using a straight jacket or demobilizing wrap. As a rights limitation, the restraint procedures must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of restraints must be documented in a member's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

-The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

-Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

-Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

-Restraint, restriction, and behavioral intervention programs shall be time-limited (maximum one year) and shall be reviewed at least quarterly.

-Corporal punishment and verbal or physical abuse are prohibited."

These safeguards are the same regardless of the type of restraint used. All restraints must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide ID waiver services must conduct its activities in accordance with these requirements. Restraint procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

Physical and chemical restraints may be allowed depending on the provider's agency policy to ensure that there is an accompanying behavioral intervention plan, documentation of each instance, and monitoring of its use. These types of restraints must be considered on an individual basis after the interdisciplinary team reviews, and enters into the restraint in the written plan of care. If a member is placed in a closed room, the time frame must be determined on an individual basis and spelled out in the member's service plan. The provider must document the use of this restraint in the member's service file each time it was utilized by staff. The provider is required to have a written policy approved by DHS on the supervision and monitoring of members placed in a closed room, e.g., monitoring on a fifteen minute basis to assure the health and welfare of the participant.

Restraint procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:

- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
 - A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
 - A list of restraints and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors.
- Restraints and behavioral interventions may only be utilized to teach replacement behaviors when non-

aversive methods of positive support have been ineffective.

- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements a restraint procedure must be able to carry out the procedure as it is written. Staff must be trained and exhibit proficiency as described below before administering restraints. A staff's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.

- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met:

- (i) the supervisor's ability to implement the procedure has been documented by a program staff person;
 - (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and

- (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The

- list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.

- Implementation of a program to alter an individual's behaviors.

Restraints and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter a member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements.

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.

- The proposed procedure is a reasonable response to the member's maladaptive target behavior.

- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.

- Use the least restrictive intervention possible.

- Ensure the health and safety of the member and that abusive or demeaning intervention is expressly prohibited.

- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:

- A Restraint and Behavioral Intervention Program that is a part of the written individual service plan developed by the member's case manager or community-based case manager, and in the provider plan of care developed for the member.

- Approval by the individual's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian, if one has been appointed by the court.

- A written endorsement from a physician for any procedure that might affect the person's health.

- A functional analysis that is defined as and includes the following components:

- (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;

- (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that

- the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;

- (iii) description of the conditions that precede the behavior in question;

(iv) description of what appears to reinforce and maintain the behavior; and
 (v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.

- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Restraints must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All restraints are explained to the member and their legal representative and agreed upon ahead of time.

Unauthorized use of restraints would be detected via interviews with the member, their family and staff and case manager or community-based case manager; through review of critical incident reports by DHS and member's case manager or community-based case manager on a daily basis; DHS and case manager or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints). Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the DHS policy for each type of agency identified restraint is observed and member rights are safeguarded. If it is found that a waiver provider is not observing DHS policy or ensuring a member's rights, adverse action is taken by the IME, which may include sanction, required corrective action, termination, etc.

The member's case manager or community-based case manager is responsible to monitor individual plans of care including the use of restraints and behavioral interventions.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The first line of responsibility for overseeing the use of restraints and ensuring safeguards are in place is the member's case manager or community based case manager. The use of restraints must be assessed as needed and identified in the member's service plan. The use of restraints would also require the development and implementation of a behavior plan and the plan would be included in the member's service plan. The case manager or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restraints would be addressed with the provider of service and corrected as needed.

The State also contracts with the HCBS Quality Oversight Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restraints. The Quality Oversight Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and Federal rules, regulations, and best practices. Further, the Quality Oversight Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether restraints are appropriately incorporated into the service plan, such that restraints are only implemented as designated in the plan (who, what, when, where, why, and how). If the Quality Oversight Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations may be made to IME Program Integrity Unit for possible provider sanctions (suspension, probation, termination, etc.).

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of restraints. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service participants that alert case managers and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Quality Oversight Unit for a targeted review. If the Quality Oversight Unit discovers that the provider is less than compliant in areas surrounding the use of restraints, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations may be made to IME Program Integrity Unit for possible provider sanctions (suspension, probation, termination, etc.).

The HCBS Quality Oversight Unit is also responsible for conducting IPES interviews with waiver participants. The IPES tool has been expanded based on the federal Personal Experience Survey (PES) tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. The HCBS Quality Oversight Unit conduct interviews either face-to-face or via telephone, to the discretion of the member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

Finally, the Quality Oversight Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of restraints, as well as data from periodic and targeted provider reviews conducted by the Quality Oversight Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to the IME. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

MCO community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restraints would be addressed with the provider of service and corrected as needed. In addition, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):***The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

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A restrictive intervention is an action or procedure that imposes a restriction of movement that limits a member's movement, access to other individuals, locations or activities, or restricts a member's rights. 441-IAC 77.25(4) describes restrictive interventions as restraints, restrictions and behavioral intervention.

The DHS policy regarding restrictive interventions is as follows, and applies to all types of restraints and restrictions methods that may be used by waiver providers. The use of any restrictive intervention as part of the waiver program is treated as rights limitations of the member receiving services. As a rights limitation, the restrictive interventions must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code 83.67(4)).

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures." All members receiving home- and community-based ID Waiver services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

- a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
- b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
- c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
- d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
- e. Corporal punishment and verbal or physical abuse are prohibited."

These safeguards are the same regardless of what type of restriction interventions are used. All restrictions must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Restriction interventions must be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

The case manager or community-based case manager has the responsibility to assess the need for the restrictive interventions, identify the specific restrictive intervention, explain why the intervention is being used, identify an intervention plan, monitor the use of the restrictive intervention, and assess and reassess need for continued use. The service plan authorizes the services to be delivered to the member and identifies how they are to be provided. Without the authorization, services cannot be provided to a member.

Providers are required to use the service plan as the basis for the development and implementation of the providers' treatment plan. The provider is responsible for developing a plan to meet the needs of the member and to train all staff on the implementation strategies of the treatment plan, such that the restriction interventions are individualized and in accordance with the previously devised plan. Providers and the case manager or community-based case manager are responsible for documenting all behavioral interventions, including restrictive interventions, in the service plan as well as the member's response to the intervention. Providers and case managers or community-based case managers are also required to submit critical incident reports to the IME, via the IMPA, any time a restrictive intervention is utilized.

Providers are required to maintain a system for the review, approval and implementation of ethical, safe, humane and efficient behavioral intervention procedures, that inform the member and his/her legal guardian of the behavioral intervention policy and procedures at the time of entry into a facility and as changes occur. Non-aversive methods of intervention must be designed and utilized as the option of first use, prior to design or implementation of any behavioral intervention containing aversive techniques.

Behavioral intervention procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a nonaversive program. Behavioral intervention procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. Corporal punishment and verbal or physical abuse are prohibited. Restrictions may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at a minimum the following components:

- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of restrictions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Restrictions and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. A person's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met:
 - (i) the supervisor's ability to implement the procedure has been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter a member's behaviors.

Behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter a member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager's or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements:

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the member's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the member and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the Behavioral Intervention Program must include:

- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as, and includes, the following components:
 - (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the

behavior;

(ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;

(iii) description of the conditions that precede the behavior in question;

(iv) description of what appears to reinforce and maintain the behavior; and

(v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.

- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.

- Documentation of all prior programs used to eliminate a maladaptive target behavior.

- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Any restriction as part of the Behavioral Intervention Program must be considered on an individual basis after a review by the interdisciplinary team and entered into the written plan of care with specific time lines. All restrictions in the Behavioral Intervention Program are explained to the member and their legal representative and agreed upon ahead of time. Unauthorized use of restrictions would be detected via interviews with the member, their family and staff and case manager or community-based case manager; through review of critical incident reports by DHS and member's case manager or community-based case manager on a daily basis; case manager or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

A restrictive intervention is an action or procedure that imposes a restriction of movement, that limits a member's movement, access to other individuals, locations or activities, or restricts a member's rights. 441-IAC 77.25(4) describes restrictive interventions as restraints, restrictions and behavioral intervention. Per the description of restrictive interventions noted in the application (G-2-b-i)above, Iowa will need to review its inclusion of restraint as a restrictive intervention.

The first line of responsibility for overseeing the use of restrictive interventions and ensuring safeguards are in place is the member's case manager or community based case manager. The use of restrictive interventions must be assessed as needed and identified in the member's service plan. The use of restrictions would also require the development and implementation of a restrictive intervention plan and the plan would be included in the participant's service plan. The member's case manager or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restrictive interventions would be addressed with the provider of service and corrected as needed.

The State contracts with the HCBS Quality Oversight Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restrictions. The Quality Oversight Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether restrictions are appropriately incorporated into the service plan, such that restrictions are only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers, regardless if serving FFS or MCO members, are required to submit major incident reports. Categories within the incident report include inappropriate use of restrictions.

FFS

For FFS members, provider reports of restrictive interventions are entered into IMPA, which trigger milestones in ISIS for fee-for-service members. These triggers alert case managers and prompt the IME HCBS Incident Reporting Specialist to conduct a review of the restrictive intervention. If it is found that the restrictive intervention demands further investigation, the issue is passed to the HCBS Quality Oversight Unit for a targeted review. If the Quality Oversight Unit discovers that the provider is less than compliant in areas surrounding the use of restrictions, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to the IME Program Integrity Unit for possible sanctions that may apply.

MCO

For MCO members, provider reports are entered into the designated MCO critical incident reporting system. In the MCO system and processes, MCO CBCMs are alerted along with the MCO Critical Incident Reporting Specialist to conduct a review of the restrictive intervention. Processes for targeted review, provider corrective actions and PI referral, if warranted, are followed as discussed in the FFS process.

IPES INTERVIEWS

The HCBS Quality Oversight Unit is also responsible for conducting IPES interviews for FFS members. The MCOs conducts the same IPES interviews for MCO members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the individual interviewed and service enrollment. IPES interviews are conducted either face-to-face or via telephone at the discretion of the waiver member. All waiver members have the right to decline an interview. The results of these interviews are presented to the state on a quarterly basis.

Finally, the HCBS Quality Oversight Unit compiles all data related to incidents associated with the inappropriate use of restrictions, as well as data from periodic and targeted provider reviews. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are

used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

MCO community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restrictive interventions would be addressed with the provider of service and corrected as needed. In addition, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DHS policy regarding seclusion is as follows, and applies to all types of seclusions that may be used by waiver providers, regardless of delivery system (i.e., FFS or MCO) Examples of seclusion include but are not limited to locking a member in a room, locking a member out of an area of their residence, or limiting community time. All incidents of seclusion must be documented in the member's service record and reported to the IME as a critical incident. As a rights limitation, the seclusion procedures must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of seclusion must be documented in a member's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures." All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

- a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
- b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
- c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
- d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
- e. Corporal punishment and verbal or physical abuse are prohibited."

The same standard is used for seclusion as a restrictive intervention. All seclusions must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Seclusion procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

Seclusion may be allowed depending on the provider's agency policy to ensure that there is an accompanying Behavioral Intervention Plan, documentation of each instance, and monitoring of its use. The use of seclusion can be considered on an individual basis after the interdisciplinary team reviews the Behavioral Intervention Plan and the plan is entered into the member's service plan of care. The provider must document the use of seclusion in the member's service file each time it was utilized by staff. The provider would be required to have a written policy approved by the HCBS Quality Oversight Unit on the supervision and monitoring of members placed in a closed room.

Seclusion procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:

- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of seclusions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Seclusions and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. A person's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each person in a role-play situation in order to document his or her

ability to implement the procedure as written.

- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (
 - i) the supervisor's ability to implement the procedure has been documented by a program staff person;
 - ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and
 - (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Seclusion and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter an member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member service plan and the case manager, health home coordinator, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements.

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the person's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the individual and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:

- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as and includes the following components:
 - (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;
 - (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;
 - (iii) description of the conditions that precede the behavior in question;
 - iv) description of what appears to reinforce and maintain the behavior; and
 - v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Seclusions must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All seclusions are explained to the member and their legal representative and agreed upon ahead of time.

Unauthorized use of seclusion would be detected via interviews with the member, their family and staff and

case manager, health home coordinator, or community-based case manager; through review of critical incident reports by DHS and member's case manager, health home coordinator, or community-based case manager on a daily basis; DHS and case manager, health home coordinator, or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints). Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the DHS policy for each type of agency identified seclusion is observed and member rights are safeguarded. If it is found that a waiver provider is not observing DHS policy or ensuring a member's rights, adverse action is taken by the IME, which may include sanction, termination, required corrective action, etc.

The member's case manager, health home coordinator, or community-based case manager, is responsible to monitor individual plans of care including the use of seclusion and behavioral interventions.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The first line of responsibility for overseeing the use of seclusion and ensuring safeguards are in place is the member's case manager, health home coordinator, or community based case manager. The use of seclusion must be assessed as needed and identified in the individual member's service plan. The use of seclusion would also require the development and implementation of a behavior plan and the plan would be included in the member's service plan. The case manager, health home coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of seclusion would be addressed with the provider of service and corrected as needed.

The State contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with seclusion. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether seclusion is appropriately incorporated into the service plan, such that seclusion is only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of seclusion. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service members that alert case managers, health home coordinators and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of seclusion, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The HCBS Quality Assurance and Technical Assistance Unit is also responsible for conducting IPES interviews with waiver members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

Finally, the Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of seclusion, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable (*do not complete the remaining items*)

Yes. This Appendix applies (*complete the remaining items*)

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Per 441 Iowa Administrative Code 77.37(15), respite providers must meet the following requirements as a condition of providing respite care under the ID waiver:

- (1) training on provision of medication according to agency policy and procedure; and
- (2) the staff member shall not provide any direct service without the oversight of supervisory staff until training is completed.

The case manager or community-based case manager and any provider responsible for medication administration must monitor the documentation of medication administration to ensure adherence to the service plan and provider policies and procedure. The provider agency frequently and routinely monitors medication administration as outlined in their policies and procedures and quality improvement plans. Provider agencies are expected to review medication administration on a daily basis to ensure health and welfare of member as well as perform quality assurance on a timeframe identified by the agency. The case manager or community-based case manager also monitor medications at a minimum annually during the annual service plan development or more frequently as needed. MCO community-based case managers monitor the documentation of medication administration to ensure adherence to the service plan and provider policies and procedures.

Monitoring includes review of the service documentation to ensure that medications have been administered at the designated times and by designated individuals. Further monitoring occurs through the report of major incidents whenever a medication error results in physicians' treatment, mental health intervention, law enforcement intervention, death, or elopement. When a major incident has occurred, follow-up, investigation, and remediation occurs as identified in G.I.d. All medication errors resulting in a major incident report or discovered via complaint are fully investigated. If it is determined that a harmful practice has been detected, the provider agency completes a corrective action plan and may face sanctions depending on severity and negligence of the circumstance.

The Iowa Medicaid program has actively managed Medicaid pharmacy benefits through a Preferred Drug List (PDL) since 2005. A governor appointed medical assistance pharmaceutical and therapeutics (P&T) committee was established for the purpose of developing and providing ongoing review of the PDL. The prior authorization department of the IME Medical Services Unit (MSU) utilizes the PDL to review medication management. First line responsibility lies with the prescriber who is contacted by fax or telephone regarding a prescription. Pharmacists review patient profiles for proper diagnosis, dosage strength and length of therapy.

The DHS Member Services Unit has established procedures to monitor Medicaid members' prescribing physicians and pharmacies. Analysis has established risk thresholds for these factors to mitigate possible abuse, harmful drug reactions, and to improve the outcomes of medication regimes for Medicaid members. When it is identified that members exceed the established risk thresholds, the member is placed in lock-in. Lock-in establishes one prescribing physician and one filling pharmacy for each member. The Member Services Unit also conducts statistical analysis of the use of certain drugs and usage patterns. Identification of trends for prescriptions and usage patterns of high risk or addictive medications is presented to DHS on a monthly or quarterly basis.

Second-line monitoring is conducted concerning the use of behavior modifying medications through a variety of mechanisms. First, member education is designed to ensure appropriate utilization (correcting overutilization and underutilization), at a minimum, and to improve adherence. Second, restriction programs, including policies, procedures, and criteria for establishing the need for the lock-in, may also be implemented. Finally, medication therapy management programs are developed to identify and target members who would most benefit, and include coordination between the participant, the pharmacist and the prescriber using various means of communication and education.

The Drug Utilization Review (DUR) Commission is a quality assurance body, which seeks to improve the quality of pharmacy services and ensure rational, cost-effective medication therapy for Medicaid members in Iowa. The commission reviews policy issues and provides suggestions on prospective DUR criteria, prior authorization guidelines, OTC coverage, and plan design issues. The DUR system provides for the evaluation of individual member profiles by a qualified professional group of physicians and pharmacists, with expertise in the clinically appropriate prescribing of covered outpatient drugs, the clinically appropriate dispensing and monitoring of outpatient drugs, drug use review, evaluations and intervention, and medical quality assurance. Members of this group also have the knowledge, ability, and expertise to target and analyze therapeutic appropriateness, inappropriate long-term use of medication, overuse/underuse/abuse/polypharmacy, lack of generic use, drug-drug

interactions, drug-disease contraindications, therapeutic duplications, therapeutic benefit issues, and cost-effective drug strengths and dosage forms. In addition, the IME MSU reviews Medicaid member records to ensure that the member had a diagnosis or rationale documented for each medication taken.

The Department of Inspections and Appeals (DIA) is responsible for Medicaid member's medication regimes for waiver members served in a Residential Care Facility for persons with Intellectual Disabilities (RCF/ID). All medical regimes are included in the member's record. Medications administered by the facility are recorded on a medical record by the individual who administers medication. All RCF/IDs are licensed facilities and must meet all Department of Inspections Administrative Rules to obtain an annually renewable license. Medical records are reviewed during licensure renewal. Persons administering medication must be a licensed nurse or physician or have successfully completed a department approved medication aide course. If the provider stores, handles, prescribes, dispenses, or administers prescription or over the counter medications the provider is required to develop procedures for the storage, handling, prescribing, dispensing, or administration of medication. For controlled substances, providers must maintain DIA procedures. If the provider has a physician on staff or under contract, the physician must review and document the provider's prescribed medication regime at least annually in accordance with current medical practice. Policies and procedures must be developed in written form by the provider for the dispensing, storage, and recording of all prescription and nonprescription medications administered, monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, including antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics. Policies and procedures are reviewed by the HCBS Specialists for compliance with state and federal regulations. If deficiencies are found, the provider is required to submit a corrective action, and follow-up surveys may be conducted based on the severity of the deficiency.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Second line responsibility is utilized when issues are more complex. Occurrences of high dosage use for certain medications or prescribing drugs for an age group where the drug is not FDA indicated are sent to DHS-IME for review. In some cases edits have been placed in the computer system so the prescriber could not prescribe for age groups not indicated.

Lock-In: Trending and analysis has been conducted by the MSU and “lock-in” strategies have been implemented for individuals who have, historically, multiple prescribers and pharmacies. Identification of these individuals allows the Medicaid payment of only one prescribing physician and one pharmacy. This allows for increased monitoring of appropriate medication management and mitigates the risk associated with pharmacological abuses and negative contraindications.

Drug Utilization Review (DUR) Commission: The DUR is a second line monitoring process with oversight by DHS. The DUR system includes a process of provider intervention that promotes quality assurance of care, patient safety, provider education, cost effectiveness and positive provider relations. Letters to providers generated as a result of the professional evaluation process identify concerns about medication regimens and specific patients. At least one Iowa licensed pharmacist is available to reply in writing to questions submitted by providers regarding provider correspondence, to communicate by telephone with providers as necessary and to coordinate face-to-face interventions as determined by the DUR.

The Department of Inspections and Appeals (DIA): This DIA is responsible for oversight of licensed facilities. DIA communicates all findings to DHS and any issues identified during the RCF/ID licensure process, or critical incidents as they arise. The DIA tracks information and provides training as necessary to improve quality. This information is also shared with DHS. Both the DIA and DHS follow-up with identified RCF/IDs to assure that action steps have been made to ensure potential harmful practices do not reoccur.

HCBS Quality Assurance Unit: DHS contracts with the Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with medication management. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines participant files, and conducts targeted reviews based on complaints, to ascertain whether medications are appropriately incorporated into the service plan. If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include medication errors. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service participants that alert service workers, case managers, and health home coordinators, and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding medication management, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

With respect to MCO members, community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of medication would be addressed with the provider of service and corrected as needed. In addition, MCOs must maintain documentation of the member’s medication management done by the MCOs clinical staff; monitor the prescribing patterns of network prescribers to improve the quality of care coordination services provided to members through strategies such as: (a) identifying medication utilization that deviates from current clinical practice guidelines; (b) identifying members whose utilization of controlled substances warrants intervention; (c) providing education, support and technical assistance to providers; and (d) monitor the prescribing patterns of psychotropic medication to children, including children in foster care. Finally, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa

Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.).

The Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of medication, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Supported Community Living and Respite Service providers must have policies and procedures developed for dispensing, storage, and recording all prescription and nonprescription medication administered. 441 Iowa Administrative Code Chapter 77.37(15) (b)(2)states:

“Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing. All medications shall be stored in their original containers, with the accompanying physician’s or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer’s name. In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.”

Providers are required to have staff trained on medication administration and provide safe oversight of medication administration. The State does not require specific medication administration curriculum to be used. Providers are responsible to assure that staff has the skills needed to administer medications safely. This can be done through providing staff with an outside medication management training program with a certification issued or an internal training provided by qualified medical staff. There are no uniform requirements in the Iowa Administrative Code for the provision of medication administration or for the self-administration of medications by Medicaid members. The HCBS Quality Oversight Unit verifies the training during the provider onsite review.

The Provider Self-Assessment quality improvement process requires providers to have a policy and procedure for the storage and provision of medication. This process requires a more uniform approach for the provider in the requirements for medication management. The Provider Self-Assessment review checklist used by the HCBS Specialist to review providers identifies the following minimum standards that the medication policy will identify:

- The provider’s role in the management and/or administration of medications
- If staff administers medications, the policy will identify the:
 - (1) training provided to staff prior to the administration of medications;
 - (2) method of documenting the administration of medications;
 - (3) storage of medications;
 - (4) the assessment process used to determine the Medicaid member’s role in the administration of medications.

The provider Self-Assessment process also requires providers to have discovery, remediation and improvement processes for medication administration. The information and results of these activities is available to DHS upon request. Currently the self-assessment process is not set forth in the Iowa Administrative Code.

Home Health agencies that provide waiver services must follow Medicare regulations for medication administration and dispensing. All medications must be stored in their original containers with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to Medicaid members and the public. Nonprescription medications shall be labeled with the Medicaid member's name. In the case of medications that are administered on an ongoing long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription. All providers of respite must develop policies that assure that personnel that administer medications have the appropriate skills and that there is oversight by medical personnel.

Provider non-medical waiver staff that administers medications must have oversight of a licensed nurse. If the medication requires, the staff is required to complete a medication management course through a community college.

The requirements for non-medical waiver providers must have in order to administer medications to Medicaid members who cannot self-administer is that the provider must have a written policy in place on what the requirements are for their staff to do this and how. If the medications are psychiatric medications the person would have to have successfully completed a medication aide class. Oversight for a staff member who administers medications that require oversight such as in the case of psychiatric medications would need to follow the requirements as spelled out through the Board of Nursing such as having oversight by a registered nurse. The HCBS Specialists through IME would oversee this policy upon regular reviews of the provider.

State oversight responsibility is described in Appendix H for the monitoring methods that include identification of problems in provider performance and support follow-up remediation actions and quality improvement activities.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Providers are required to complete incidents reports for all occurrences meeting the criteria for major and minor incidents and make the incident reports and related documentation available to DHS upon request. Major incidents must be reported to the BLTC via IMPA. Providers must ensure cooperation in providing pertinent information regarding incidents as requested by DHS.

As part of the major incident reporting process described in Appendix G-1, DHS will review and follow-up on all medication errors that lead to a participant hospitalization or death. This can include the wrong dosage, the wrong medication delivered, medication delivered at the wrong time, Medicaid delivery not documented, unauthorized administration of medication, or missed dosage. Providers are required to submit all medication errors, whether major or minor, to the participant's service worker, case manager, health home coordinator, or community-based case manager when they occur. The service worker, case manager, health home coordinator, or community-based case manager monitors the errors and makes changes to the participant's service plan as needed to assure the health and safety of the member.

The Provider Self-Assessment quality improvement process requires providers to have a policy and procedure regarding medication administration and medication management. The Provider Self-Assessment process also requires that providers have discovery, remediation, and improvement processes for medication administration and medication errors. Specifically, providers are required to have ongoing review of medication management and administration to ensure that medications are managed and administered appropriately. Providers are also required to track and trend all medication errors to assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to DHS upon request and will be reviewed as part of the ongoing Self-Assessment process conducted by the HCBS Specialists. This will include random sampling of providers, incident specific review (complaint and IR follow up) and on-site provider review held every five years. DHS is in the process of promulgating rules to establish the Provider Self-Assessment quality improvement process in the Administrative Code.

Other professionals or family members may report medication error incidents at any time as a complaint. Suspected abuse is reported to the reporting hotline operated by the Department of Human Services.

(b) Specify the types of medication errors that providers are required to *record*:

Providers must track and trend all major and minor incident reports. Per Chapter 441 Iowa Administrative Code 77.25(1), “major incidents” are defined as an occurrence involving a participant during service provision that: (1) results in a physical injury to or by the participant that requires a physician’s treatment or admission to a hospital; (2) results in the death of any person; (3) requires emergency mental health treatment for the participant; (4) requires the intervention of law enforcement; (5) requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; (6) constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or (7) involves a participant’s location being unknown by provider staff who are assigned protective oversight. Service providers, provider staff, DHS TCM, MCO CBCM, health home coordinators, and community-based case managers are required to submit incident reports as they are witnessed or discovered. All major incidents must be reported within 48 hours of witnessing or discovering an incident has occurred, using the IME’s Iowa Medicaid Portal Access (IMPA) System. Suspected abuse may be reported to the statewide abuse reporting hotline operated by DHS.

Per Chapter 441 Iowa Administrative Code 77.25(1), “minor incidents” are defined as an occurrence involving a participant during service provision that is not a major incident and that: (1) results in the application of basic first aid; (2) results in bruising; (3) results in seizure activity; (4) results in injury to self, to others, or to property; or (5) constitutes a prescription medication error. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider’s system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the participant’s file.

Providers are required to record all medication errors, both major and minor, that occur. Providers are required to track and trend all medication errors and assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to DHS upon request and will be reviewed as part of the ongoing Self-Assessment process conducted by the HCBS Specialists.

(c) Specify the types of medication errors that providers must *report* to the state:

Only major incidents of medication errors that affect the health and safety of the member, as defined by the major incident criteria, are required to be reported to the State. All medication errors, both major and minor, are required to be reported to the member’s guardian, case manager, health home coordinator, or community-based case manager.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Iowa Medicaid Enterprise (IME) is responsible for the oversight of waiver providers in the administration of medications to waiver members. Oversight monitoring is completed through IMPA, the provider Self-Assessment process and monitoring of the participant by the member's case manager or community-based case manager. With respect to MCO members, community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of medication would be addressed with the provider of service and corrected as needed. In addition, MCOs must maintain documentation of the member's medication management done by the MCOs clinical staff; monitor the prescribing patterns of network prescribers to improve the quality of care coordination services provided to members through strategies such as:

- (a) identifying medication utilization that deviates from current clinical practice guidelines;
- (b) identifying members whose utilization of controlled substances warrants intervention;
- (c) providing education, support and technical assistance to providers; and
- (d) monitor the prescribing patterns of psychotropic medication to children, including children in foster care.

Finally, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.). All of these processes have been described in detail in this Appendix.

All medication errors are considered either major or minor incidents, as noted in Subsection "iii.b" above. Major incidents are reported to the department and follow the incident reporting follow up protocol of the department.

DHS contracts with the HCBS Quality Oversight Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with medication management. The Quality Oversight Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and Federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether medications are appropriately incorporated into the service plan. If the Quality Oversight Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to the Program Integrity Unit for possible sanctions (suspension, probation, termination, etc.).

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate medication administration. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service members that alert case managers and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding medication administration, the provider is required to complete a CAP and implement the CAP to 100% compliance. Again, if it is found that the circumstances are more serious, recommendations are made to the Program Integrity Unit for possible sanctions (suspension, probation, termination, etc.).

The Quality Oversight Unit compiles all data related to incidents reported in IMPA associated with the inappropriate medication administration, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to the IME. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and

welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-a1: The IME will measure the total number and percent of IAC-defined major critical incidents requiring follow-up escalation that were investigated. Numerator = # of critical incidents that received follow-up as required; Denominator = # of critical incidents requiring follow-up escalation

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Data collected in the FFS and MCO CIR databases.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted Entity, including MCO"/>	Annually	Stratified Describe Group: <input type="text"/>

	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

HW-a2: The IME will measure CIs that identify a reportable event of abuse, neglect, exploitation, or unexplained death and were followed upon appropriately. Numerator = # of CIRs that identified a report was made to DHS protective services and/or appropriate follow up was initiated; Denominator = # of CIs that identified a reportable event of abuse, neglect, exploitation, and/or unexplained death

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

FFS and MCO CIR databases.

Responsible Party for	Frequency of data	Sampling Approach
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data collection/generation <i>(check each that applies):</i>	collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted Entity, including MCO"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

HW-a3 The IME will measure the number and percent of members who received information on how to report abuse, neglect exploitation and unexplained deaths

Numerator: # of members service plans that indicate the members received

information on how to report abuse, neglect, exploitation and unexplained deaths

Numerator: Total # of service plans reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text" value="MCO and contracted entity"/>	Annually	Stratified Describe Group:

		IA.0213 AIDS/HIV (.05%) IA.0242 ID (47%) IA.0299 BI (6%) IA.0345 PD (4%) IA.0819 CMH (4%) IA.4111 HD Waiver (9%) IA.4155 - Elderly Waiver (30%)
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/> MCO and contracted entity	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

b. Sub-assurance: *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-b1: The IME will identify all unresolved critical incidents which resulted in a targeted review and were completed to resolution. Numerator = # of targeted reviews resulting from an incident which were resolved within 60 days; Denominator = # of critical incidents that resulted in a targeted review.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

FFS/HCBS Unit and MCO data obtained from CIR databases.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify:	Annually	Stratified Describe Group:

Contracted Entity including MCO		
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 398 1262 483" type="text"/>
	Other Specify: <input data-bbox="716 622 954 707" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="405 1285 798 1370" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="868 1574 1260 1659" type="text"/>

Performance Measure:

HW-b2 The IME will measure the number and percent of critical incidents where the root cause was identified
Numerator: the number and percent of critical incidents where the root cause was identified
Denominator: total number of critical incident reports

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% +/- 5%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">MCO and contracted entity</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px;"> IA.0213 AIDS/HIV (.05%) IA.0242 ID (47%) IA.0299 BI (6%) IA.0345 PD (4%) IA.0819 CMH (4%) IA.4111 HD Waiver (9%) IA.4155 - Elderly Waiver (30%) </div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: MCO and contracted entity	Annually
	Continuously and Ongoing
	Other Specify:

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-c1: The IME will measure the total # & % of providers with policies for restrictive measures that are consistent with State and Federal policy and rules, and followed as written. Numerator = # providers reviewed that have policies for restrictive measures that were implemented as written; Denominator = total # of providers reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Provider's policies and procedures. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
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State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted Entity including MCO"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

d. Sub-assurance: *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-d1: The IME will measure the number and percent of providers meeting state and federal requirements relative to individual waivers. Numerator = # of Quality Assurance reviews that did not receive a corrective action plan; Denominator = # of provider Quality Assurance Reviews completed.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

All QA reviews that don't result in a corrective action. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		<input type="text"/>
Other Specify: <input type="text" value="Contracted Entity"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The HCBS Quality Oversight Unit and each MCO is responsible for monitoring and analyzing data associated with the major incidents reported for members on waivers. For both FFS and MCO members, new Critical Incident Reports (CIRs) are reviewed on a daily basis and follow-up is initiated immediately; routine monitoring continues through resolution.

Data is pulled from the data warehouse and from MCO reporting on a regular basis for programmatic trends, individual issues and operational concerns. Reported incidents of abuse, medication error, death, rights restrictions, and restraints are investigated further by the HCBS Incident Reporting Specialist as each report is received. The analysis of this data is presented to the state on a quarterly basis.

The HCBS Quality Oversight Unit, and each MCO, is responsible for conducting IPES interviews with waiver members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The HCBS Incident Reporting Specialist and each MCO analyzes data for individual and systemic issues. Individual issues require communication with the case manager or community based case manager to document all efforts to remediate risk or concern. If these efforts are not successful, staff continues efforts to communicate with the case manager, the case manager's supervisor, and protective services when necessary. All remediation efforts of this type are documented in the monthly and quarterly reports.

The HCBS Specialists conducting interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. MCO are responsible for research and follow up to flagged responses. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes to provider policy.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: contracted entity and MCOs	Annually
	Continuously and Ongoing
	Other

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
	Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 10px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state

will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The IME is the single state agency that retains administrative authority of Iowa's HCBS Waivers. Iowa remains highly committed to continually improve the quality of services for all waiver programs. The IME discovered over the course of submitting previous 1915(c) waiver evidence packages that previously developed performance measures were not adequately capturing the activities of the IME. For this reason, state staff developed new performance measures to better capture the quality processes that are already occurring or being developed.

The QIS developed by Iowa consolidates and stratifies performance data across all seven 1915(c) waivers. The HCBS waiver population will be identified based waiver enrollment at a single point in time. A 95% confidence level with a 5% error rate for the total waiver population is calculated. In an effort to ensure each waiver is represented within the sample identified for the reporting year, the specific waiver enrollment will be divided by the total waiver population to identify the percentage the specific waiver contributes to the overall waiver population during that reporting year. The significant sample will be multiplied by the percentage identified for each waiver to identify the number of surveys/reviews that need to be completed for each waiver. This process is completed for each waiver to ensure that the 95% confidence level is met and that each waiver is appropriately sampled. A common capture date will be used to count enrollment for all waivers.

Iowa will begin consolidated performance data collection April 1, 2020. The first consolidated evidence reports will be for the Physical Disability and Health and Disability Waivers reports due to CMS in January 2021.

IA.0213 - AIDS/HIV Waiver (.05%)
 IA.0242 - ID Waiver (47%)
 IA.0299 - BI Waiver (6%)
 IA.0345 - PD Waiver (4%)
 IA.0819 - CMH Waiver (4%)
 IA.4111 - HD Waiver (9%)
 IA.4155 - Elderly Waiver (30%)

Based on contract oversight and performance measure implementation, the IME holds weekly policy staff and long term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff. Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance committee meets monthly to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. ISIS will only be utilized for fee-for-service participants.

All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas. The QM/QI program must have objectives that are measurable, realistic and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 Subpart E and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program. The State has developed a draft-reporting manual for the MCOs to utilize for many of the managed care contract reporting requirements. The managed care contract also allows for the State to request additional regular and ad hoc reports.

Iowa has acknowledged that improvements are necessary to capture data at a more refined level, specifically individual remediation. While each contracting unit utilizes their own electronic tracking system or OnBase (workflow management), further improvements must be made to ensure that there are not preventable gaps collecting individual remediation. The State acknowledges that this is an important component of the system; however the terrain where intent meets the state budget can be difficult to manage.

The IME supports infrastructure development that ensures choice is provided to all Medicaid members seeking services and that these services are allocated at the most appropriate level possible. This will increase efficiency

as less time is spent on service/funding allocation and more time is spent on care coordination and improvement. A comprehensive system of information and referrals ensures that all individuals are allowed fully informed choices prior to facility placement.

The Medicaid Quality Utilization and Improvement Data System (MQUIDS) is a data entry and retrieval application designed to facilitate the Medical Services contractor’s job functions including level of care determinations, medical service prior authorizations, documentation review and the retention of other pertinent member data . The content is guided by the business and policy requirements of medical review. The medical services reviews frequently involve the documentation of health information on individual members that must be protected

A comprehensive system of information and referrals shall also be developed such that all individuals are allowed fully informed choices prior to facility placement. Many program integrity and ACA initiatives will assist in system improvements. These include improvements to provider screening at enrollment, tighter sanction rules, and more emphasis on sustaining quality practices.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">Contracted Entities (including MCOs)</div>	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The IME has hired a Quality Assurance Manager to oversee the data compilation and remediation activities associated with the revised performance measures. The QA Manager and State policy staff address oversight of design changes and the subsequent monitoring and analysis during the weekly policy and monthly quality assurance meetings. Prior to dramatic system design changes, the State will seek the input of stakeholders and test/pilot changes that are suggested and developed. Informational letters are sent out to all relevant parties prior to implementation with contact information of key staff involved. This workflow is documented in logs and in informational letters found within the DHS computer server for future reference. Stakeholder involvement and informational letters are requested or sent out on a weekly/monthly/ongoing basis as policy engages in the continuous quality improvement cycle.

Unit managers, policy staff and the QA committee continue to meet on a regular basis (weekly or monthly) to monitor performance and work plan activities. The IME Management and QA committees include representatives from the contracted units within the IME as well as State staff. These meetings serve to present and analyze data to determine patterns, trends, concerns, and issues in service delivery of Medicaid services, including by not limited to waiver services. Based on these analyses, recommendations for changes in policy are made to the IME policy staff and bureau chiefs. This information is also used to provide training, technical assistance, corrective action, and other activities. The unit managers and committees monitor training and technical assistance activities to assure consistent implementation statewide. Meeting minutes/work plans track data analysis, recommendations, and prioritizations to map the continuous evaluation and improvement of the system. IME analyzes general system performance through the management of contract performance benchmarks, ISIS reports, and Medicaid Value Management reports and then works with contractors, providers and other agencies regarding specific issues. The QA committee directs workgroups on specific activities of quality improvement and other workgroups are activated as needed.

In addition to developing QM/QI programs that include regular, ongoing assessment of services provided to Medicaid beneficiaries, MCOs must maintain a QM/QI Committee that includes medical, behavioral health, and long-term care staff, and network providers. This committee is responsible for analyzing and evaluating the result of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action, and ensuring appropriate follow-up. This committee is also responsible for reviewing and approving the MCOs' QM/QI program description, annual evaluation, and associated work plan prior to submission to DHS.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The IME reviews the overall QIS no less than annually. Strategies are continually adapted to establish and sustain better performance through improvements in skills, processes, and products. Evaluating and sustaining progress toward system goals is an ongoing, creative process that has to involve all stakeholders in the system.

Improvement requires structures, processes, and a culture that encourage input from members at all levels within the system, sophisticated and thoughtful use of data, open discussions among people with a variety of perspectives, reasonable risk-taking, and a commitment to continuous learning. The QIS is often revisited more often due to the dynamic nature of Medicaid policies and regulations, as well as the changing climate of the member and provider communities.

In accordance with 42 CFR 438 Subpart E, the State will maintain a written strategy for assessing and improving the quality of services offered by MCOs including, but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries. MCOs must comply with the standards established by the State and must provide all information and reporting necessary for the State to carry out its obligations for the State quality strategy. MCOs are contractually required to ensure that the results of each external independent review are available to participating health care providers, members, and potential members of the organization, except that the results may not be made available in a manner that discloses the identity of any individual patient. Further, MCOs must establish stakeholder advisory boards that advise and provide input into: (a) service delivery; (b) quality of care; (c) member rights and responsibilities; (d) resolution of grievances and appeals; (e) operational issues; (f) program monitoring and evaluation; (g) member and provider education; and (h) priority issues identified by members. In accordance with 42 CFR 438 Subpart E, the State will regularly monitor and evaluate the MCOs' compliance with the standards established in the State's quality strategy and the MCOs' QM/QI program. The State is in the process of developing specific processes and timelines to report results to agencies, waiver providers, participants, families, other interested parties and the public. This will include strategies such as leveraging the Medical Assistance Advisory Council (MAAC).

The HCBS Quality Assurance Unit (QAU) completes review of HCBS enrolled providers on a three-five year cycle. During the onsite review HCBS ensures personnel are trained in:

- Abuse reporting
- Incident reporting
- Have current mandatory reporter training
- Individual member support needs
- Rights restrictions
- Provision of member medication

In addition HCBS QAU reviews the centralized incident report file, appeals and grievances, and any allegations of abuse. During the review of service documentation any incident identified in narrative which falls under the Incident description in 77.25(3), is required to have an incident report filed. The agencies tracking and trending of incident reports is also reviewed during the onsite review. Any areas the agency may be out of compliance in results in the requirement of a corrective action plan. HCBS

gives the provider 30 days to submit a time limited corrective action plan which will remediate the deficiency. 45 days after the corrective action plan has been accepted HCBS follows up and requires the agency to submit evidence that the corrective action plan was put into place.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :**Other** (Please provide a description of the survey tool used):

The state of Iowa uses the Participant Experience Survey (PES). The PES is an interview tool developed by MEDSTAT under a contract from CMS. Iowa has added a few Iowa specific questions around employment to the PES

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

This section applies to all Intellectual Disability Waiver services, including CDAC and Personal Care Services provided through the state's self-direction program, the Consumer Choices Option (CCO). Self-directed services are not treated differently than other waiver services.

The IME Program Integrity (PI) unit conducts audits on all Medicaid provider types including HCBS providers. Any suspected fraud is referred to the Department of Inspection and Appeals (DIA) Medicaid Fraud and Control Unit (MFCU). The IME PI unit vendor is contractually required to review a minimum of 60 cases in each quarter across all provider types.

The PI unit reviews include providers who are outliers on multiple parameters of cost, utilization, quality of care, and/or other metrics. Reviews include referrals and complaints received. Reviews include the review of claims data and service documentation to detect such aberrancies as up-coding, unbundling, and billing for services not rendered. The review may involve desk audits or provider on-site reviews. During a desk audit the provider is required to submit records for the PI unit to review. The PI unit must initiate appropriate action to recover improper payments on the basis of its reviews. They must work with the Core MMIS contractor to accomplish required actions on providers, including requests to recover payment through the use of credit and adjustment procedures.

Reviews conducted by the Program Integrity unit for Fee-For-Service (FFS) members are mainly done post pay; some may be done pre-pay if a specific provider has been previously reviewed and found to be out of compliance. MCOs are required to follow the same standards and processes as used for FFS.

The PI vendor must report findings from all reviews to the IME, including monthly and quarterly written reports detailing information on provider review activity, findings and recoveries. A request for provider records by the PI unit include Form 470-4479, Documentation Checklist, which lists the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d.” to document the basis for services or activities provided. Reviews are conducted in accordance with Iowa Administrative Code 441-79.4 (<https://www.legis.iowa.gov/docs/ACO/chapter/441.79.pdf>).

The vast majority of HCBS claims are paid through MCOs. The IME Program Integrity unit only reviews claims submitted through the FFS system for members who are not enrolled in an MCO. There is a relatively small number of HCBS claims in the FFS universe and, as such, statistical sampling is unnecessary. Since April 2016, the IME Program Integrity Unit has reviewed an average of 1,568 ID Waiver FFS claims per month or 7.21% of the total ID Waiver claims which includes both FFS and MCO claims. It is anticipated that the state will continue with the average number of claims reviewed in the future. It is more efficient and productive for the PI unit to use more targeted strategies to identify providers for review. Strategies such as data analysis and algorithms to identify billing aberrancies, as well as referrals and complaints that come from various sources are used to identify providers. The PI vendor may conduct on-site reviews, but there is no requirement for a set percentage of reviews to be conducted on-site.

The prescribed methodology for review is determined on a case-by-case basis and is generally determined based on the nature and scope of the issue identified. In previous years, all HCBS claims were paid through the FFS system; currently the vast majority of HCBS claims are paid by MCOs. The state compares the results of the MCO program integrity efforts to the results achieved in past years. However, MCO operations tend to rely more on prior authorization of services and pre-payment claims editing to control costs, and as such this type of comparison will not be straightforward and may not provide useful information.

When the PI vendor identifies an overpayment for FFS claims, a Preliminary Report of Tentative Overpayment (PROTO) letter is sent to the provider. The PROTO letter gives the provider an opportunity to ask for a re-evaluation and they may submit additional documentation at that time. After the re-evaluation is complete, the provider is sent a Findings and Order for Repayment (FOR) letter to notify them of any resulting overpayment. Both the PROTO and FOR letters are reviewed and signed off by IME State PI staff prior to mailing. The FOR letter includes appeal rights to inform the provider that they may appeal through the State Fair Hearing process. When overpayments are recovered, claims adjustments are performed which automatically results in the federal financial participation (FFP) returned to CMS.

The IME enters into and establishes a contract with each MCO prior to assigning members to be managed by the MCO. The contract is a comprehensive document that details the requirements of the MCO in managing the Medicaid and waiver services for those members on the ID waiver. The IME sends each MCO a monthly eligibility file to identify member enrollment with the MCO for authorization of the capitated payment to the MCO. Any change in eligibility status, whether from FFS to MCO, MCO to FFS or a change from one MCO to another, is identified in the monthly eligibility file.

The Organized Health Care Delivery System (OHCDs) Medicaid audit is subject to the same standards and processes as

outlined for FFS. The state's contracted MCOs are also responsible for safeguarding against, and investigating reports of, suspected fraud and abuse. MCOs are required to fully cooperate with the IME PI Unit by providing data and ongoing communication and collaboration. Per 42 CFR 438.608 and 42 CFR Part 455, MCOs must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The MCO PI Plan must be updated annually and submitted to the IME for review and approval. The MCOs are also required to make referral to the IME and the MFCU for any suspected fraudulent activity by a provider. On a monthly basis, the MCOs must submit an activity report to the IME, which outlines the MCO's PI-related activities and findings, progress in meeting goals and objectives, and recoupment totals. Each MCO is also required to meet in person with the IME PI Unit, the IME Managed Care Oversight Bureau, and the MFCU on at least a quarterly basis to coordinate on open cases and review the MCO's program integrity efforts. Iowa's MCOs continuously conduct reviews/audits on providers in their networks. The degree to which these include HCBS providers varies over time depending on tips received and leads from data analytics.

The state trends data from the MCOs monthly reports to identify trends in number of tips received, number of audits/investigations opened, the number of closed referrals to MFCU, and the amount of overpayments recovered.

The IME reviews MCO reports monthly to monitor their fraud and abuse activities. From this information, the IME analyzes and trends the data received. A monthly dashboard is created that captures metrics on number of tips, new audits and investigations, number of fraud referrals, amount of overpayments collected, and cost savings/cost avoidance numbers. These numbers are shared with IME leadership monthly and with the MCOs during their 1:1 monthly meeting with the IME Program Integrity unit. At the end of the fiscal year the current MCO stats are compared to previous years and results of this analysis is presented to IME leadership and the MCOs.

The MCOs must also coordinate all PI efforts with IME and Iowa's MFCU. MCOs must have a method in place to verify whether services reimbursed were actually provided to members as billed by providers. The methods must comply with 42 CFR Part 455 by suspending payments to a provider after the IME PI unit determines there is a credible allegation of fraud unless otherwise directed by the IME or law enforcement. MCOs shall comply with all requirements for provider disenrollment and termination as required by 42 CFR §455.

The Auditor of the State has the responsibility to conduct periodic independent audit of the waiver under the provisions of the Single Audit Act. The State Auditor's office performs an audit of the Medicaid waivers every year. The audit is performed based upon randomly selected members across all waivers and the review includes various payment types, provider agreements, eligibility, proper payment, etc.

All HCBS provider cost reports are subject to a desk review audit and, if necessary, a field audit. However, the Waiver does not require the providers to secure an independent audit of their financial statements.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

FA-a1: The IME will determine the number and percent of FFS reviewed claims supported by provider documentation. Numerator = # of reviewed paid claims where documents supports the units of service; Denominator = # of reviewed paid claims

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Program Integrity reviews claims and provider documentation for providers already under review.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95% +/- 5%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">Contracted Entity</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">IA.0213 AIDS/HIV (.05%) IA.0242 ID (47%) IA.0299 BI (6%) IA.0345 PD (4%) IA.0819 CMH (4%) IA.4111 HD Waiver (9%) IA.4155 - Elderly Waiver (30%)</div>

	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><i>Reviewed monthly by pulling a sample of claims from the two most utilized codes per waiver the 1st qtr., remaining qtrs. will include claims from other codes in the waiver, ranked by utilization.</i></p> </div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 10px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>

Performance Measure:

FA-a2: The IME will determine the number of clean claims that are paid by the managed care organizations within the timeframes specified in the contract. Numerator = # of clean claims that are paid by the managed care organization within the timeframes specified in the contract; Denominator = # of Managed Care provider claims.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Claims Data Adjudicated claims summary, claims aging summary, and claims lag report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <input type="text"/>
<i>Other</i> <i>Specify:</i> <input type="text" value="Contracted Entity including MCOs"/>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i> <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other</i> <i>Specify:</i> <input type="text"/>
	<i>Other</i> <i>Specify:</i> <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

FA-b1: The IME will measure the number and percent of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for waiver services provided. Numerator = # of reviewed claims paid using IME-approved rate methodologies; Denominator = # of reviewed paid claims.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

The Data Warehouse Unit query pulls paid claims data for all seven of the HCBS waivers.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<i>State Medicaid</i>	<i>Weekly</i>	<i>100% Review</i>

<i>Agency</i>		
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <input type="text"/>
<i>Other Specify:</i> <input type="text" value="Contracted Entity and MCOs"/>	<i>Annually</i>	<i>Stratified Describe Group:</i> <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <input type="text"/>
	<i>Other Specify:</i> <input type="text"/>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i> <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other Specify:</i>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input style="width: 100%; height: 30px;" type="text"/>

Performance Measure:

FA-b2: The IME will measure the number of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology.

Numerator: # of Capitation payments made to the MCOs at the approved rates through the CMS certified MMIS. Denominator: # of capitation payments made through the CMS certified MMIS.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

MMIS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input style="width: 100%; height: 30px;" type="text"/>
Other Specify: <input style="width: 100%; height: 30px;" type="text"/> contracted entity	Annually	Stratified Describe Group: <input style="width: 100%; height: 30px;" type="text"/>
	Continuously and Ongoing	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> Specify: <input style="width: 100%; height: 20px;" type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Program Integrity unit samples provider claims each quarter for quality. These claims are cross-walked with service documentation to determine the percentage of error associated with coding and documentation. This data is reported on a quarterly basis.

MCO claims data is compared to the contractual obligations for MCO timeliness of clean claim payments. Data is provided to the HCBS staff as well as to the Bureau of Managed Care.

MCO contractual definition of a clean claim: A claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments; require screening of all claims, referral to MFCU, or provider suspension.

The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a quarterly basis.

If during the review of capitation payments the IME determines that a capitation was made in error, that claim is adjusted to create a corrected payment.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i> <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are*

available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

All provider rates are part of Iowa Administrative Code (IAC) Rules and are subject to public comment any time there is change. Rate setting methodologies used by the Department are identified in IAC 441- 79.1(1) Types of reimbursement.

Payments for waiver services for fee-for-service (FFS) enrollees are made by DHS through the MMIS. For FFS members, providers submit claims monthly for services provided by the agency. Providers may submit manual or electronic claims form. Electronic claims must utilize a HIPAA compliant software, PC-ACE Pro 32, and be processed by the IME Provider Services Unit. Manual claims are directed to the Iowa Medicaid Enterprise (IME)/Provider Services Unit. Providers submit a claim form that accurately reflects: (1) the provider's approved NPI provider number; (2) the appropriate waiver procedure code(s) that correspond to the waiver services authorized in the ISIS service plan; and (3) the appropriate waiver service unit(s) and fee that corresponds to the ISIS service plan.

The IME issues provider payments weekly every Monday. The MMIS system edits insure that payments will not be made for services that are not included in an approved ISIS service plan. Any change to ISIS data generates a new authorization milestone for the case manager. The ISIS process culminates in a final ISIS milestone that verifies an approved service plan has been entered into ISIS.

For payments made by the IME: Providers are informed about the process for billing Medicaid directly through annual provider training, IME informational bulletins, and the IME provider manual. When a provider enrolls as a Medicaid provider, the IME Provider Services Unit mails the provider information on billing Medicaid directly. The Provider billing manual is also available on the Iowa DHS website at: <http://dhs.iowa.gov/policy-manuals/medicaid-provider>. At the time of service plan development, the case manager shares provider rates with the member and the member can chose a provider based on their rates. They may also get rate information from a service provider or by viewing the rates in the IAC available on the DHS website. When a service is authorized in a member's service plan, the providers of services receives a Notice of Decision (NOD), which indicates the participant's name, provider's name, service to be provided, the dates of service to be provided, units of service authorized, and reimbursement rate for the service.

Daily SCL, residential based SCL, full day adult day care, and full day Day Habilitation services are reimbursed using a tiered rate fee schedule. Member assignment to a tiered rate fee schedule is defined in Iowa Administrative Code (IAC) 441-79.1(30).

Personal emergency response, respite, transportation, prevoc services, supported employment, adult day care (15 min. and 1/2 day units), Day Habilitation (15 – min. units), financial management services, independent support broker and home and vehicle modification are reimbursed by fee schedules. The fee schedule is the actual charge made by the provider not to exceed the upper payment limit. The upper payment limit is established to address the reasonableness of the charge. If the provider rate is under the upper max, it is reasonable.

Fee schedules are determined by the department with advice and consultation from the appropriate professional group at the time the fee schedule is first developed. The fees reflect the amount of time and resources involved in each procedure. The fee scheduled rate is applied to all providers equally, meaning all providers may charge up to the maximum fee schedule rate. Provider may charge less than the maximum fees schedule. Individual service rate adjustments are made periodically to correct any rate inequity. With the ID waiver, this is a legislative appropriation process through provider association and individual providers lobbying efforts. The legislature can direct IME to increase or decreased provider rates through a legislative mandate. There is no set cycle for the Legislature to increase or decrease HCBS provider rates. The IME will change the IAC Rules accordingly. All provider rates are part of IAC and are subject to public comment any time there is a rate rule change. Information is on the website and is distributed to stakeholders when there is a change. Rate determination methods are set forth in IAC and subject to the State's Administrative Procedures Act, which requires a minimum twenty-day public comment period.

If product cost is involved, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.*
- (2) The maximum allowance under the fee schedule for the item of service in question.*

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Variations in this methodology are set forth in subrules IAC 79.1(3) to 79.1(9) and 79.1(15). Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website at:

dhs.iowa.gov/ime/providers/csrp/fee-schedule.

SCL provided in 15- minute units is a retrospectively limited prospective rate. With this rate, providers are reimbursed on the basis of a rate for a unit of service calculated prospectively based on projected or historical costs of operation.

- *The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.*
- *The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.*
- *The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.*

Interim Medical Monitoring and Treatment rates are established two ways and is based on the enrollment type of the IMMT provider. IMMT services provided by a supported community living provider is a retrospectively limited prospective rate as noted for SCL provided in 15 – minute units above. IMMT provided by a home health agency is a cost-based rate for home health aide services provided by a home health agency. The difference in how rates are developed for IMMT is due to the use of existing rate setting methodologies for services similar to IMMT. An SCL provider will use the same rate setting methodology for IMMT as it does for SCL 15- minutes units since the service costs for both SCL and IMMT are the same or very similar. IMMT provided by a home health agency will use the same rate setting methodology used for a home health aide as they would be the same or similar cost for providing IMMT. CDAC (Skilled and Unskilled) are reimbursed on the basis of the agreement of the member and the provider with an upper payment limit established by the State.

For services that the participant self-directs (CCO), the member negotiates a rate with the entity providing services, goods, and supports.

For the FMS and ISB services, the IME sets the upper rate limit for those services as established in IAC 441-79.1(2).

Respite provided by home health agencies use the maximum Medicare rate converted to a fifteen-minute unit.

Home health and nursing Services are based on a fee schedule as determined by Medicare.

For transportation, the rate is fee schedule. Providers are paid at the provider's rate, not to exceed the upper rate limit at 441 IAC 79.1(2).

Prevocational service rates are fee schedules.

For payments made to FFS by the IME: Providers are informed of the process for billing and payment through Medicaid through annual provider training, IME info bulletins, and the IME provider manual. The Provider billing manual is also available on the Iowa DHS website at: <http://dhs.iowa.gov/policy-manuals/medicaid-provider>.

For payments made by an MCO: Providers are informed about the process for billing and payment through the annual provider training, IME informational bulletins, and the MCO provider manual and related materials. MCO provider materials are available through each MCO portal.

CCO Employment Agreement form 470-4427 Item 13: The employee will sign and submit a bi-weekly accurate time sheet of all services rendered including the type of service rendered, the date, and the number of service hours delivered. Time sheets must be signed by both the employer and employee. The employee acknowledges that the employee is responsible for submitting time sheets to the FMS within five business days from the end of the payroll cycle. Time sheets received after five business days will be paid with the next payroll cycle. Time sheets received after 30 days of the last day of service provided will not be paid.

441 IAC 79.1 sets forth the principles governing reimbursement of providers of medical and health services. Specifically,

“[t]he basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider’s allowable costs of operation or a fee schedule. Providers of service must accept reimbursement based upon the department’s methodology without making any additional charge to the member. Reimbursement types are described at 441 IAC 79.1(1).

Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer’s suggested retail price shall be made at the dealer’s cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices. For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality. Payment for used equipment shall not exceed 80 percent of the purchase allowance. No allowance shall be made for delivery, freight, postage, or other the CDAC and CCO services were set in accordance with 441 IAC 79.1(1)c.

Setting the capitation rates with the MCOs is the responsibility of the IME Managed Care Unit. MCO capitation rate development methodologies are described in the §1915(b) waiver and associated materials.

- b. Flow of Billings.** *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state’s claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

For fee-for-service participants, providers shall submit claims on a monthly basis for waiver services provided to each member served by the provider agency. Providers may submit manual or electronic claim forms. Electronic claims must utilize a HIPAA compliant software, as identified in the provider billing manual. Claims submitted manually shall be directed to the Iowa Medicaid Enterprise (IME)/Provider Services Unit.

Fee for Service provider billing manuals are located at <https://dhs.iowa.gov/ime/providers/rulesandpolicies>. Waiver service fee schedule upper payment rates are located in the Iowa Administrative Code at <https://dhs.iowa.gov/ime/providers/rulesandpolicies>, Chapter 79.

Providers shall submit a claim form that accurately reflects the following:

- (1) the provider’s approved NPI provider number;*
- (2) the appropriate waiver procedure code(s) that correspond to the waiver services authorized in the ISIS service plan; and*
- (3) the appropriate waiver service unit(s) and fee that corresponds to the ISIS service plan.*

The member name and identification number are both also required on the claim form.

For the Consumer Choices Option (CCO), the flow of billing by the Financial Management Service (FMS) is the same as other HCBS Waiver enrolled providers, i.e., once the CCO services have been provided, the FMS will bill for the CCO services provided in the previous month based on the services provided to the member by the CCO employee(s). The FMS pays the CCO employees and for the individual directed goods and services during the month then bills for services through the MMIS system.

The IME issues provider payments weekly on each Monday of the month. The MMIS system edits insure that payment will not be made for services that are not included in an approved ISIS service plan. Any change to ISIS data generates a new authorization milestones for the case manager. The ISIS process culminates in a final ISIS milestone that verifies an approved service plan has been entered into ISIS. ISIS data is updated daily into MMIS.

For MCO members, providers bill the managed care entity with whom a member is enrolled in accordance with the terms of the provider’s contract with the MCO. Providers may not bill Medicaid directly for services provided to MCO members.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS system edits to make sure that claim payments are made only when a member is eligible for waiver payments and when the services are included in the service plan. An member is eligible for a Medicaid Waiver payment on the date of service as verified in ISIS. The billing validation method includes the date the service was provided, time of service provision, and name of actual member providing the service. Several entities monitor the validity of claim payments:

- (1) case manager, or health home coordinator ensures that the services were provided by reviewing paid claims information made available to them for each of their members through ISIS;*
- (2) the Iowa Department of Human Services Bureau of Purchased Services performs financial audits of providers to ensure that the services were provided;*
- (3) the IME Program Integrity Unit performs a variety of reviews by either random sample or outlier algorithms.*

The MMIS system includes system edits to ensure that prior to issuing a capitation payment to an MCO the member is eligible for the waiver program and is enrolled with the MCO. MCOs must implement system edits to ensure that claim payments are made only when the member is eligible for waiver payments on the date of service. The MCOs are required to develop and maintain an electronic community-based case management system that captures and tracks service delivery against authorized services and providers. The State monitors MCO compliance and system capability through pre-implementation readiness reviews and ongoing monitoring such as a review of sampled payments to ensure that services were provided and were included in the member's approved plan of care. The MCOs are also responsible for program integrity functions with DHS review and oversight.

When inappropriate billings are discovered (i.e.: overpayments determined) the provider is notified in writing of the overpayment determination. The provider either submits a refund check to the IME or the overpayment is set as a credit balance within the MMIS. Future claim payments are then used to reduce and eliminate the credit balance.

Meanwhile, the overpayments are recorded and reported to the state data warehouse using an end-of-month A/R reporting process. Any overpayments determined during a particular month are reported for that month. Any recoveries of these overpayments are similarly recorded and reported to the state data warehouse using the same end-of-month A/R process and for the month in which the recoveries were made. The dates on which the respective overpayments occurred and the recoveries made are part of this month-end A/R reporting. Bureau of Fiscal Management staff then extracts this reporting from the data warehouse to construct the CMS-64 report, the official accounting report submitted by the Department to CMS (the state's claiming mechanism for FFP). The CMS-64 report shows CMS what Iowa's net expenditures are for the quarter and is used to determine a final claim of federal funds. The federal dollar share of any overpayments not recovered within 12 months of the payment itself must be returned to CMS and this is accomplished through the CMS-64 report as well.

Prevention of member coercion:

The case managers and MCO community based case managers are responsible for conducting the interdisciplinary team for each member and ensuring the unencumbered right of the member to choose the provider for each service that will meet the member's needs.

The HCBS Unit completes the Iowa Personal Experience Survey to a random sample of members (95% confidence level). A specific survey question relates to the members' ability to choose their providers. Any indication of coercion will result in followup action by the HCBS staff.

The IME HCBS Unit observes a random sample of interdisciplinary team (IDT) meetings conducted by MCO community based case managers. This allows the HCBS Unit to note any member coercion in choice of providers. HCBS staff then requests the final service plan to ensure that the final plan does include the services, units and providers chosen by the member. Any changes and omissions require followup by the HCBS staff for resolution by the MCO.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services for fee-for-service enrollees are made by DHS through the MMIS. For fee-for-service members, providers shall submit claims on a monthly basis for waiver services provided to each member served by the provider agency. Providers may submit manual or electronic claim forms. Electronic claims must utilize a HIPAA compliant software, PC-ACE Pro 32, and shall be processed by the IME Provider Services Unit. Manual claims shall be directed to the Iowa Medicaid Enterprise (IME)/Provider Services Unit. Providers shall submit a claim form that accurately reflects the following: (1) the provider's approved NPI provider number; (2) the appropriate waiver procedure code(s) that correspond to the waiver services authorized in the ISIS service plan; and (3) the appropriate waiver service unit(s) and fee that corresponds to the ISIS service plan.

The IME issues provider payments weekly on each Monday of the month. The MMIS system edits insure that payment will not be made for services that are not included in an approved ISIS service plan. Any change to ISIS data generates a new authorization milestone for the case manager or health home care coordinator. The ISIS process culminates in a final ISIS milestone that verifies an approved service plan has been entered into ISIS. ISIS data is updated daily into MMIS.

For payments made by the IME: Providers are informed about the process for billing Medicaid directly through annual provider training, IME informational bulletins, and the IME provider manual. When a provider has been enrolled as a Medicaid provider, IME Provider Services mails the provider an enrollment packet that includes how the provider can bill Medicaid directly. The Provider billing manual is also available on the Iowa DHS website at: <http://dhs.iowa.gov/policy-manuals/medicaid-provider>.

Capitation payments to MCOs are made by the MMIS. The MMIS has recipient eligibility and MCO assignment information. When a recipient is enrolled in an MCO, this is reflected on his/her eligibility file and monthly payment flows from the MMIS to the MCO via an 837 transaction. A monthly payment to the MCO on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

The claim details submitted for payment is reviewed and reconciled by the IME and supporting claim detail is maintained. Payment for these services is recorded in the state's accounting system. The accounting records and claim detail provide the audit trail for these payments.

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For payments made by the IME:

Providers are informed about the process for billing Medicaid directly through annual provider training, IME informational bulletins, and the IME provider manual.

When a provider has been enrolled as a Medicaid provider, IME Provider Services mails the provider an enrollment packet that includes how the provider can bill Medicaid directly. The Provider billing manual is also available on the Iowa DHS website at: <http://dhs.iowa.gov/policy-manuals/medicaid-provider>.

The FMS directly pays the CCO self-directed services and individual directed goods Member employees through the Consumer Choices Option (CCO) program are issued instructions on billing through the FMS as authorized on the member's monthly CCO budget. The FMS bills through the MMIS system the self-directed services and individual directed goods that have been paid by the FMS during the previous month. The FMS bills through the MMIS system in the month following the provision of self-directed services.

IME exercises oversight of the fiscal agent through both the ISIS system and through our Core Unit that manages the MMIS system.

For MCO enrollees, for the self-direction option of the waivers, payments will be made to a financial management service provider. Providers are informed about the process for billing by the MCO. The FMS must meet the provider qualifications established by the state, pass a readiness review approved by the state, and be enrolled as a Medicaid provider with the state. The state will also oversee the operations of the financial management service by providing periodical audits.

When a member is being managed by a MCO, all waiver and Medicaid services that a member can receive are paid through the MCO and that there are no waiver services reimbursed outside of the capitated payments.

IME exercises oversight of the fiscal agent through both the ISIS system and through the IME Core Unit. The IME Core Unit performs a myriad of functions for the Iowa Medicaid Enterprise including, but not limited to, processing and paying claims, handling mail, and reporting. This unit also maintains and updates the automated eligibility reporting system known as ELVS. IME has regularly scheduled meetings with Core that has thresholds of measurements they are required to meet to assure quality.

Additional oversight is provided to the program by the IME Program Integrity (PI) payment review detailed in appendix I-1 of this amendment. The Iowa Administrative Code (IAC) for the FMS requires the FMS to conduct an annual independent audit. The FMS also has an on-site review conducted by the HCBS Quality Oversight Unit (QOU). As part of the Quality Assurance contract with the IME, the HCBS QOU reviews the FMS provider for compliance with State and federal requirements. The FMS is an enrolled Medicaid waiver provider and as such, the Home and Community Based QOU conducts an on-site FMS quality assurance review every three years.

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The two State Resource Centers (Woodward and Glenwood) are the only two state agencies that provide community based services on the Intellectual Disabilities waiver. The Resource Centers provide Supported Community Living, Supported Employment and respite services. All HCBS services provided by the State Resource Centers are provided in settings that are in compliance with the HCBS settings rules.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the

state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

For fee-for-service enrollees, providers receive and retain 100% of the amount claimed to CMS for waiver services. The payment to capitated MCOs is reduced by a performance withhold amount as outlined in the contracts between DHS and the MCOs. The MCOs are eligible to receive some or all of the withheld funds based on the MCO's performance in the areas outlined in the contract between DHS and the MCOs.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

Enrolled Medicaid providers can choose to subcontract to non-enrolled providers for the provision of Home and Vehicle Modifications. The authorization for the service and the Medicaid payment for the authorized service is made to the enrolled Medicaid provider that would then forward payment to the subcontractor in accordance with their contract.

Any subcontractor who is qualified to enroll with Iowa Medicaid is encouraged to do so. No provider is denied Medicaid enrollment for those services that they are qualified to provide. Waiver providers are not required to contract with an OHCDS in order to furnish services to members.

When the case manager or community-based case manager has assessed the need for any waiver service, the member is offered the full choice of available providers. The member has the right to choose from the available providers; the list of providers is available through the case manager or community-based case manager, and is also available through the IME and MCO websites. In accordance with the Iowa Administrative Code, all subcontractors must meet the same criteria guidelines as enrolled providers and the contracting enrolled provider must confirm that all criteria is met.

The Financial Management Services entities are designated as an OHCDS as long as they meet provider qualifications as specified in C-3. The FMS is the only ID waiver provider designated as an OHCDS. Iowa Medicaid Enterprise (the state Medicaid agency) executes a provider agreement with the OHCDS providers and MCOs contract with an IME enrolled Financial Management Services solution. The Financial Management Services provided by the OHCDS is voluntary and an alternative billing and access is provided to both waiver members and providers. Members have free choice of providers both within the OHCDS and external to these providers. Providers may use the alternative certification and billing process developed by the Iowa Medicaid Enterprise. Members are given this information during their service plan development. Providers are given this information by the OHCDS. The Designated OHCDS reviews and certifies that established provider qualifications have been met for each individual or vendor receiving Medicaid reimbursement. Annually each provider will be recertified as a qualified provider.

Employer/employee agreements and timesheets document the services provided if waiver members elect to hire and manage their own workers. The purchase of goods and services is documented through receipts and/or invoices. For each purchase for fee-for-service members, Medicaid funding from the MMIS to the provider of the service is accurately and appropriately tracked through the use of Iowa's ISIS system. Financial oversight and monitoring of the OHCDS is administered by the Iowa Medicaid Enterprise through an initial readiness review to determine capacity to perform the waiver services and throughout the year using a reporting system, random case file studies and the regular Medicaid audit process. MCOs are contractually required to develop a system to track all OHCDS Financial Management Services, which is subject to DHS review and approval. Further, the MCOs maintain financial oversight and monitoring with ongoing review and authority retained by DHS.

A provider must enroll with Medicaid prior to being eligible to enroll with a managed care organization. They are not required to contract with a MCO as this is a provider/MCO contractual arrangement. However, Medicaid will notify the MCO of all providers eligible to provide services.

Each MCO has different systems that maintains authorized service plans. Many of the services are prior authorized and claims are adjudicated against the authorizations.

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d)

how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:***

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability**I-5: Exclusion of Medicaid Payment for Room and Board****a. Services Furnished in Residential Settings. Select one:**

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

As specified in Iowa Administrative Code, Iowa does not reimburse for room and board costs, except as noted for providers of out-of-home respite services. The provider manuals contain instructions for providers to follow when providing financial information to determine rates. The manuals state that room and board cannot be included in the cost of providing services. Most respite payments are based upon fee schedules detailed in the Iowa Administrative Code. The fee schedule has no allowance for room and board charges. Respite provided by a home health agency is limited to the established Medicare rate.

The exclusion of room and board from reimbursement is ensured by the Provider Cost Audit Unit. When providers submit cost report documentation and rate setting changes, the Provider Cost Audit Unit accounts for all line items and requests justification for all allocated costs (administrative and other). If it is determined that a provider has attempted to include room and board expenses in cost audits or rate setting documentation, the provider is instructed to make the adjustment and further investigation is conducted to determine if previous reimbursement needs to be recouped by the Iowa Medicaid Enterprise.

All providers of waiver services are subject to a billing audit completed by the Department of Human Services Bureau of Purchased services.

Any payment from an MCO to residential settings is made explicitly for the provision of services as defined by this waiver and excludes room and board. As part of the ongoing monitoring process of MCOs, the State will ensure that payments to residential settings are based solely on service costs.

Appendix I: Financial Accountability**I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver****Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:**

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

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Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

--

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	36066.02	17119.33	53185.35	152552.00	8050.00	160602.00	107416.65
2	36056.53	17632.91	53689.44	156366.00	8252.00	164618.00	110928.56
3	37424.55	18161.90	55586.45	160275.00	8458.00	168733.00	113146.55
4	38252.01	18706.76	56958.77	164282.00	8669.00	172951.00	115992.23
5	39444.88	19267.96	58712.84	168389.00	8886.00	177275.00	118562.16

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	14203		14203

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 2	14345		14345
Year 3	14488		14488
Year 4	14633		14633
Year 5	14780		14780

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) is expected to remain the same throughout the five years of the waiver. The fiscal data for each HCBS Waiver 372 is based on each designated waiver statistical year. Maintaining ALOS at 353 for all 5 years of the waiver renewal is based on historical data along with assumptions provided by the State’s actuary. The CMS 372 reports used to develop and report ALOS is July 1, 2012 – June 30, 2017 that incorporated historical ALOS back to 07/01/12.

In this waiver renewal, unduplicated participant values were increased by 1% each waiver year. The increase in the number of unduplicated participants reflects the managed care program’s incentive to move individuals from the institutional setting to the HCBS waiver community setting.

The increases in the total unduplicated number of participants were trended at a 1% increase based on the assumptions provided by the State’s actuary and historical trends.

Limitation on the Number of Participants Served at any Point in Time were projected at 1% growth each year based on historical growth and average monthly costs per recipient on the waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D is not impacted by the increase in the population. However, Factor D is impacted by the transition from a fee-for-service program to a managed care capitation rate program. In the prior waiver amendment, Factor D was adjusted due to the transition to managed care. In this submission, the post-managed care unduplicated participant values were increased by 1% each waiver year. The increase in the number of unduplicated participants reflects the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.

The new participants are not expected to change the characteristics (risk profile) of the population. The underlying capitation rates reflect the risk profile of those qualifying for the HCBS waiver, which are reflected in Factor D and Factor D'.

Under this waiver renewal, Factor D and Factor D' increase on an annual basis at approximately 3.0% per year. The projected increase was based on an estimate of future increases to capitation rates under the managed care program, assumptions provided by the State's actuary, and historical trends based on the five most recent 372 submissions. The dates of the 372 submissions used were for the five years from July 1, 2012 to June 30, 2017.

The WY1 renewal Factor D cost was estimated utilizing WY5 of the prior waiver renewal as a baseline for the projection. The prior Appendix J submission illustrates an estimated Factor D cost of \$39,509.55 in WY5. The WY5 costs are based on a blend of the Factor D cost included in the IA Health Link capitation rates (for IA Health Link members) and historical FFS costs for the residual members not enrolled in IA Health Link. Most Intellectual Disability (ID) Waiver members are enrolled in the IA Health Link program.

The Factor D capitation rate cost is greater than the Factor D cost reported in the most recent 372 report, because the capitation rates paid for the ID Waiver members are greater than the historical Factor D costs.

- ii. Factor D' Derivation.** *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is not impacted by the increase in the population. However, Factor D' is impacted by the transition from a fee-for-service program to a managed care capitation rate program. In the prior waiver amendment, Factor D' was adjusted due to the transition to managed care. In this submission, the post-managed care unduplicated participant values were increased by 1% each waiver year. The increase in the number of unduplicated participants reflects the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.

The new participants are not expected to change the characteristics (risk profile) of the population. The underlying capitation rates reflect the risk profile of those qualifying for the HCBS waiver, which are reflected in Factor D and Factor D'.

Under this waiver renewal, Factor D and Factor D' increase on an annual basis at approximately 3.0% per year. The projected increase was based on an estimate of future increases to capitation rates under the managed care program, assumptions provided by the State's actuary, and historical trends based on the five most recent 372 submissions. The dates of the 372 submissions used were for the years from July 1, 2012 to June 30, 2017.

The WY1 renewal Factor D' cost was estimated utilizing WY5 of the prior waiver renewal as a baseline for the projection. The prior Appendix J submission illustrates an estimated Factor D' cost of \$8,454.89 in WY5. The WY5 costs are based on a blend of the Factor D' cost included in the IA Health Link capitation rates (for IA Health Link members) and historical FFS costs for the residual members not enrolled in IA Health Link. Most ID Waiver members are enrolled in the IA Health Link program.

The Factor D' capitation rate cost is greater than the Factor D' cost reported in the most recent 372 report, because the capitation rates paid for the ID Waiver members are greater than the historical Factor D' costs.

- iii. Factor G Derivation.** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Factor G derivation is based on MMIS reports dated July 1, 2012 through June 30, 2017. Factor G projections were increased by 2.5% per year based on historical increases and on assumptions provided by the State’s actuary.

The CMS 372 reports that the State files annually are based on the MMIS reports mentioned above. The CMS 372 reports used to develop and report ALOS are from July 1, 2012 – June 30, 2017.

The change in the number of lives does not have any influence over the calculation of Factor G and/or Factor G’ and are established based on historical data and were carried forward based on an average of the five years from the prior 1915(c) waiver filing.

The annual trend factor was 2.5% per user for Factor G and G’. Consideration was given to historical trends between waiver years for the ID waiver and the actuarial assumptions accounting for the transition to manage care from the State’s actuary when estimating the trend factor.

iv. Factor G’ Derivation. The estimates of Factor G’ for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G’ derivation is based on MMIS reports dated July 1, 2012 through June 30, 2017. Factor G’ projections were increased by 2.5% per year based on historical increases and on assumptions provided by the State’s actuary.

The CMS 372 reports that the State files annually are based on the MMIS reports mentioned above. The CMS 372 reports used to develop and report ALOS are from July 1, 2012 – June 30, 2017.

The change in the number of lives does not have any influence over the calculation of Factor G and/or Factor G’ and are established based on historical data and were carried forward based on an average of the five years from the prior 1915(c) waiver filing.

The annual trend factor was 2.5% per user for Factor G and G’. Consideration was given to historical trends between waiver years for the ID waiver and the actuarial assumptions accounting for the transition to manage care from the State’s actuary when estimating the trend factor.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Adult Day Care	
Day Habilitation	
Prevocational Services	
Residential Based Supported Community Living	
Respite	
Supported Employment	
Home Health Aide Services	
Nursing	
Financial Management Services	
Independent Support Broker	
Individual Directed Goods and Services	
Self Directed Community Support and Employment	
Self Directed Personal Care	

Waiver Services	
Consumer Directed Attendant Care (CDAC) - skilled	
Consumer Directed Attendant Care (CDAC) - unskilled	
Home and Vehicle Modification	
Interim Medical Monitoring and Treatment	
Personal Emergency Response or Portable Locator System	
Supported Community Living	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							4110155.80
Adult Day Care-Full Day	<input type="checkbox"/>	Day	368	130.87	65.75	3166530.52	
Adult Day Care-Half Day	<input type="checkbox"/>	Half Day	238	68.29	34.34	558128.71	
Adult Day Care - 15 Minutes	<input type="checkbox"/>	15 Minutes	5	1245.33	4.15	25840.60	
Adult Day Care-Full Day - FFS	<input type="checkbox"/>	Day	34	130.87	65.75	292559.88	
Adult Day Care-Half Day - FFS	<input type="checkbox"/>	Half Day	22	68.29	34.34	51591.73	
Adult Day Care - 15 Minutes - FFS	<input type="checkbox"/>	15 Minutes	3	1245.33	4.15	15504.36	
Day Habilitation Total:							42467400.64
Day Habilitation, ID Waiver, Per Day	<input type="checkbox"/>	Day	3825	102.59	75.17	29497215.40	
Day	<input type="checkbox"/>					8410239.62	
GRAND TOTAL:							512245716.16
Total: Services included in capitation:							425173990.30
Total: Services not included in capitation:							87071725.86
Total Estimated Unduplicated Participants:							14203
Factor D (Divide total by number of participants):							36066.02
Services included in capitation:							29935.51
Services not included in capitation:							6130.52
Average Length of Stay on the Waiver:							353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation, ID Waiver, 15 Minutes		15 Minutes	3123	1047.86	2.57		
Day Habilitation, ID Waiver, Per Day - FFS		Day	460	102.59	75.17	3547377.54	
Day Habilitation, ID Waiver, 15 Minutes - FFS		15 Minutes	376	1047.86	2.57	1012568.08	
Prevocational Services Total:							16289815.66
Prevocational Service, full day		Day	1615	110.52	61.11	10907511.68	
Prevocational Service, hour		Hour	1436	69.23	36.02	3580902.37	
Prevocational Service, full day - FFS		Day	201	110.52	61.11	1357529.32	
Prevocational Service, hour - FFS		Hour	178	69.23	36.02	443872.30	
Residential Based Supported Community Living Total:							2853915.57
Residential Based Supported Community living - day		Day	48	192.89	284.53	2634383.60	
Residential Based Supported Community living - day - FFS		Day	4	192.89	284.53	219531.97	
Respite Total:							11196035.90
Respite Resident Camp-Weeklong		15 Minutes	279	130.28	4.81	174834.46	
Respite-RCF/ID		15 Minutes	1	204.00	3.82	779.28	
Respite-HHA Specialized		15 Minutes	2	558.00	11.19	12488.04	
Respite-ICF/ID		15 Minutes	2	170.67	3.76	1283.44	
Teen Day Camp - 13 to						17214.00	
GRAND TOTAL:							512245716.16
Total: Services included in capitation:							425173990.30
Total: Services not included in capitation:							87071725.86
Total Estimated Unduplicated Participants:							14203
Factor D (Divide total by number of participants):							36066.02
Services included in capitation:							29935.51
Services not included in capitation:							6130.52
Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
21 Years Old		15 Minutes	6	755.00	3.80		
Group Specialized Summer Day Camp		15 Minutes	64	137.40	11.10	97608.96	
Respite-Homa Care Agency & Non-Facility, Group		15 Minutes	1022	584.83	3.50	2091936.91	
Respite-Homa Care Agency & Non-Facility, Basic Individual		15 Minutes	2481	593.71	4.10	6039277.49	
Respite-Homa Care Agency & Non-Facility, Specialized		15 Minutes	10	772.67	9.52	73558.18	
Respite-Camp		15 Minutes	212	689.16	3.15	460221.05	
Respite-HHA Basic Individual		15 Minutes	2	828.00	5.17	8561.52	
Group Summer Day Camp - Group Recreational		15 Minutes	13	687.20	3.80	33947.68	
Respite-Nursing Facility		15 Minutes	1	528.00	3.55	1874.40	
Respite Resident Camp-Weeklong - FFS		15 Minutes	67	130.28	4.81	41985.34	
Respite-RCF/ID - FFS		15 Minutes	0	204.00	3.82	0.00	
Respite-HHA Specialized - FFS		15 Minutes	0	558.00	11.19	0.00	
Respite-ICF/ID - FFS		15 Minutes	1	170.67	3.76	641.72	
Teen Day Camp - 13 to 21 Years Old - FFS		15 Minutes	2	755.00	3.80	5738.00	
Group Specialized Summer Day Camp - FFS		15 Minutes	15	137.40	11.10	22877.10	
GRAND TOTAL:						512245716.16	
Total: Services included in capitation:						425173990.30	
Total: Services not included in capitation:						87071725.86	
Total Estimated Unduplicated Participants:						14203	
Factor D (Divide total by number of participants):						36066.02	
Services included in capitation:						29935.51	
Services not included in capitation:						6130.52	
Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite-Homa Care Agency & Non-Facility, Group - FFS		15 Minutes	248	584.83	3.50	507632.44	
Respite-Homa Care Agency & Non-Facility, Basic Individual - FFS		15 Minutes	601	593.71	4.10	1462960.81	
Respite-Homa Care Agency & Non-Facility, Specialized - FFS		15 Minutes	3	772.67	9.52	22067.46	
Respite-Camp - FFS		15 Minutes	51	689.16	3.15	110713.55	
Respite-HHA Basic Individual - FFS		15 Minutes	0	828.00	5.17	0.00	
Group Summer Day Camp - Group Recreational - FFS		15 Minutes	3	687.20	3.80	7834.08	
Respite-Nursing Facility - FFS		15 Minutes	0	528.00	3.55	0.00	
Supported Employment Total:							18086267.15
Maintain Employment - Individual		15 Minutes	647	18.12	66.30	777277.33	
Maintain Employment - Small Group		15 Minutes	810	1102.77	2.84	2536812.11	
Long Term Job Coaching		Month	2725	4.28	1129.18	13169626.34	
Maintain Employment - Individual - FFS		15 Minutes	37	18.12	66.30	44450.17	
Maintain Employment - Small Group - FFS		15 Minutes	104	1102.77	2.84	325714.15	
Long Term Job Coaching - FFS		Month	255	4.28	1129.18	1232387.05	
Home Health							15265549.00

GRAND TOTAL:						512245716.16
Total: Services included in capitation:						425173990.30
Total: Services not included in capitation:						87071725.86
Total Estimated Unduplicated Participants:						14203
Factor D (Divide total by number of participants):						36066.02
Services included in capitation:						29935.51
Services not included in capitation:						6130.52
Average Length of Stay on the Waiver:						353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Aide Services Total:							
Home Health Aide Services		Hour	218	9.59	791.95	1655666.51	
Home Health Aide Services - FFS		Hour	1792	9.59	791.95	13609882.50	
Nursing Total:							30033.36
Nursing Care in the Home/LPN; Per Hour		Visit	15	12.00	24.78	4460.40	
Nursing Care in the Home/RN; Per Hour		Visit	5	12.00	24.78	1486.80	
Nursing Care in the Home/LPN; Per Hour - FFS		Visit	62	12.00	24.78	18436.32	
Nursing Care in the Home/RN; Per Hour - FFS		Visit	19	12.00	24.78	5649.84	
Financial Management Services Total:							3445374.37
Financial Management Services		Month	218	9.59	178.74	373677.42	
Financial Management Services - FFS		Month	1792	9.59	178.74	3071696.95	
Independent Support Broker Total:							340797.91
Independent Support Broker		Month	218	9.59	17.68	36962.16	
Independent Support Broker - FFS		Month	1792	9.59	17.68	303835.75	
Individual Directed Goods and Services Total:							1062680.37
Individual Directed Goods and Services		Month	218	9.59	55.13	115255.88	
Individual Directed		Month				947424.49	
GRAND TOTAL:							512245716.16
Total: Services included in capitation:							425173990.30
Total: Services not included in capitation:							87071725.86
Total Estimated Unduplicated Participants:							14203
Factor D (Divide total by number of participants):							36066.02
Services included in capitation:							29935.51
Services not included in capitation:							6130.52
Average Length of Stay on the Waiver:							353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goods and Services - FFS			1792	9.59	55.13		
Self Directed Community Support and Employment Total:							15265549.00
Self Directed Community Support and Employment	Month		218	9.59	791.95	1655666.51	
Self Directed Community Support and Employment - FFS	Month		1792	9.59	791.95	13609882.50	
Self Directed Personal Care Total:							14189761.03
Self Directed Personal Care	Month		218	9.59	736.14	1538989.01	
Self Directed Personal Care - FFS	Month		1792	9.59	736.14	12650772.02	
Consumer Directed Attendant Care (CDAC) - skilled Total:							746389.42
CDAC - Individual - 15 Minutes	15 Minutes		30	4389.30	3.60	474044.40	
CDAC - Agency - 15 Minutes	15 Minutes		20	1195.82	5.41	129387.72	
CDAC - Individual - 15 Minutes - FFS	15 Minutes		7	4389.30	3.60	110610.36	
CDAC - Agency - 15 Minutes - FFS	15 Minutes		5	1195.82	5.41	32346.93	
Consumer Directed Attendant Care (CDAC) - unskilled Total:							6660024.23
CDAC- Individual - 15 Minutes	15 Minutes		267	4389.30	3.60	4218995.16	
CDAC- Agency - 15 Minutes	15 Minutes		178	1195.82	5.41	1151550.74	
GRAND TOTAL:							512245716.16
Total: Services included in capitation:							425173990.30
Total: Services not included in capitation:							87071725.86
Total Estimated Unduplicated Participants:							14203
Factor D (Divide total by number of participants):							36066.02
Services included in capitation:							29935.51
Services not included in capitation:							6130.52
Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CDAC- Individual - 15 Minutes - FFS		15 Minutes	64	4389.30	3.60	1011294.72	
CDAC- Agency - 15 Minutes - FFS		15 Minutes	43	1195.82	5.41	278183.61	
Home and Vehicle Modification Total:							137927.75
Home and Vehicle Modifications		Occurrence	41	1.02	2291.92	95848.09	
Home and Vehicle Modifications - FFS		Occurrence	18	1.02	2291.92	42079.65	
Interim Medical Monitoring and Treatment Total:							438104.02
IMMT - Nurse		15 Minutes	0	2720.00	8.54	0.00	
IMMT - Aide or CNA		15 Minutes	16	1824.67	6.89	201151.62	
IMMT - Nurse - FFS		15 Minutes	1	2720.00	8.54	23228.80	
IMMT - Aide or CNA - FFS		15 Minutes	17	1824.67	6.89	213723.60	
Personal Emergency Response or Portable Locator System Total:							119929.40
Personal Emergency Response-Ongoing		Installation	217	10.52	44.14	100764.56	
Personal Emergency Response-Initial		Installation	51	1.00	221.81	11312.31	
Personal Emergency Response-Ongoing - FFS		Installation	15	10.52	44.14	6965.29	
Personal Emergency Response-Initial - FFS		Installation	4	1.00	221.81	887.24	
Supported Community Living Total:							345918000.10
GRAND TOTAL:							512245716.16
Total: Services included in capitation:							425173990.30
Total: Services not included in capitation:							87071725.86
Total Estimated Unduplicated Participants:							14203
Factor D (Divide total by number of participants):							36066.02
Services included in capitation:							29935.51
Services not included in capitation:							6130.52
Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Community Living, Per Day		Day	4459	323.27	190.55	274670380.21	
Supported Community Living, 15 Minutes		15 Minutes	5044	1038.78	8.15	42702791.51	
Supported Community Living, Per Day - FFS		Day	401	323.27	190.55	24701238.50	
Supported Community Living, 15 Minutes - FFS		15 Minutes	454	1038.78	8.15	3843589.88	
Transportation Total:							13622005.50
Per Trip		Trip	3056	1098.90	2.48	8328431.23	
Per Mile		Mile	1428	3873.13	0.62	3429114.38	
Per Trip - FFS		Trip	485	1098.90	2.48	1321756.92	
Per Mile - FFS		Mile	226	3873.13	0.62	542702.98	
GRAND TOTAL:						512245716.16	
Total: Services included in capitation:						425173990.30	
Total: Services not included in capitation:						87071725.86	
Total Estimated Unduplicated Participants:						14203	
Factor D (Divide total by number of participants):						36066.02	
Services included in capitation:						29935.51	
Services not included in capitation:						6130.52	
Average Length of Stay on the Waiver:							353

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							4264294.00
Adult Day Care-Full Day		Day	375	130.87	67.07	3291544.09	
Adult Day Care-Half Day		Half Day	242	68.29	35.03	578912.09	
Adult Day Care - 15 Minutes		15 Minutes	5	1245.33	4.23	26338.73	
Adult Day Care-Full Day - FFS		Day	35	130.87	67.07	307210.78	
Adult Day Care-Half Day - FFS		Half Day	23	68.29	35.03	55020.57	
Adult Day Care - 15 Minutes - FFS		15 Minutes	1	1245.33	4.23	5267.75	
Day Habilitation Total:							44178737.97
Day Habilitation, ID Waiver, Per Day		Day	3901	102.59	76.67	30683609.25	
Day Habilitation, ID Waiver, 15 Minutes		15 Minutes	3186	1047.86	2.62	8746822.74	
Day Habilitation, ID Waiver, Per Day - FFS		Day	470	102.59	76.67	3696820.39	
Day Habilitation, ID Waiver, 15 Minutes - FFS		15 Minutes	383	1047.86	2.62	1051485.60	
Prevocational Services Total:							16944511.67
Prevocational Service, full day		Day	1647	110.52	62.33	11345708.01	
Prevocational Service, hour		Hour	1464	69.23	36.74	3723698.93	
Prevocational Service, full day - FFS		Day	205	110.52	62.33	1412185.88	
Prevocational Service, hour - FFS		Hour	182	69.23	36.74	462918.86	
Residential							2966968.40
GRAND TOTAL:							517230940.01
Total: Services included in capitation:							440791370.86
Total: Services not included in capitation:							76439569.15
Total Estimated Unduplicated Participants:							14345
Factor D (Divide total by number of participants):							36056.53
Services included in capitation:							30727.88
Services not included in capitation:							5328.66
Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Based Supported Community Living Total:							
Residential Based Supported Community living - day		Day	49	192.89	290.22	2743046.25	
Residential Based Supported Community living - day - FFS		Day	4	192.89	290.22	223922.14	
Respite Total:							11640671.18
Respite Resident Camp-Weeklong		15 Minutes	284	130.28	4.91	181667.64	
Respite-RCF/ID		15 Minutes	1	204.00	3.90	795.60	
Respite-HHA Specialized		15 Minutes	2	558.00	11.41	12733.56	
Respite-ICF/ID		15 Minutes	2	170.67	3.84	1310.75	
Teen Day Camp - 13 to 21 Years Old		15 Minutes	6	755.00	3.88	17576.40	
Group Specialized Summer Day Camp		15 Minutes	65	137.40	11.32	101098.92	
Respite-Homa Care Agency & Non-Facility, Group		15 Minutes	1042	584.83	3.57	2175532.51	
Respite-Homa Care Agency & Non-Facility, Basic Individual		15 Minutes	2531	593.71	4.18	6281202.44	
Respite-Homa Care Agency & Non-Facility, Specialized		15 Minutes	10	772.67	9.71	75026.26	
Respite-Camp		15 Minutes	216	689.16	3.21	477835.98	
Respite-HHA Basic Individual		15 Minutes	2	828.00	5.27	8727.12	
GRAND TOTAL:						517230940.01	
Total: Services included in capitation:						440791370.86	
Total: Services not included in capitation:						76439569.15	
Total Estimated Unduplicated Participants:						14345	
Factor D (Divide total by number of participants):						36056.53	
Services included in capitation:						30727.88	
Services not included in capitation:						5328.66	
Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Summer Day Camp - Group Recreational		15 Minutes	13	687.20	3.88	34662.37	
Respite-Nursing Facility		15 Minutes	1	528.00	3.62	1911.36	
Respite Resident Camp-Weeklong - FFS		15 Minutes	69	130.28	4.91	44137.56	
Respite-RCF/ID - FFS		15 Minutes	0	204.00	3.90	0.00	
Respite-HHA Specialized - FFS		15 Minutes	0	558.00	11.41	0.00	
Respite-ICF/ID - FFS		15 Minutes	1	170.67	3.84	655.37	
Teen Day Camp - 13 to 21 Years Old - FFS		15 Minutes	2	755.00	3.88	5858.80	
Group Specialized Summer Day Camp - FFS		15 Minutes	16	137.40	11.32	24885.89	
Respite-Homa Care Agency & Non-Facility, Group - FFS		15 Minutes	253	584.83	3.57	528224.30	
Respite-Homa Care Agency & Non-Facility, Basic Individual - FFS		15 Minutes	613	593.71	4.18	1521286.88	
Respite-Homa Care Agency & Non-Facility, Specialized - FFS		15 Minutes	3	772.67	9.71	22507.88	
Respite-Camp - FFS		15 Minutes	52	689.16	3.21	115034.59	
Respite-HHA Basic Individual - FFS		15 Minutes	0	828.00	5.27	0.00	
Group Summer Day Camp - Group		15 Minutes	3	687.20	3.88	7999.01	
GRAND TOTAL:						517230940.01	
<i>Total: Services included in capitation:</i>						440791370.86	
<i>Total: Services not included in capitation:</i>						76439569.15	
<i>Total Estimated Unduplicated Participants:</i>						14345	
<i>Factor D (Divide total by number of participants):</i>						36056.53	
<i>Services included in capitation:</i>						30727.88	
<i>Services not included in capitation:</i>						5328.66	
<i>Average Length of Stay on the Waiver:</i>							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Recreational - FFS							
Respite-Nursing Facility - FFS		15 Minutes	0	528.00	3.62	0.00	
Supported Employment Total:							18826644.01
Maintain Employment - Individual		15 Minutes	660	18.12	67.63	808800.70	
Maintain Employment - Small Group		15 Minutes	826	1102.77	2.90	2641575.26	
Long Term Job Coaching		Month	2780	4.28	1151.76	13704101.18	
Maintain Employment - Individual - FFS		15 Minutes	38	18.12	67.63	46567.31	
Maintain Employment - Small Group - FFS		15 Minutes	106	1102.77	2.90	338991.50	
Long Term Job Coaching - FFS		Month	261	4.28	1151.76	1286608.06	
Home Health Aide Services Total:							201983.83
Home Health Aide Services		Hour	34	24.97	212.87	180722.37	
Home Health Aide Services - FFS		Hour	4	24.97	212.87	21261.46	
Nursing Total:							31246.08
Nursing Care in the Home/LPN; Per Hour		Visit	15	12.00	25.28	4550.40	
Nursing Care in the Home/RN; Per Hour		Visit	5	12.00	25.28	1516.80	
Nursing Care in the Home/LPN; Per Hour - FFS		Visit	64	12.00	25.28	19415.04	
Nursing Care in the Home/RN; Per Hour - FFS		Visit	19	12.00	25.28	5763.84	
GRAND TOTAL:							517230940.01
Total: Services included in capitation:							440791370.86
Total: Services not included in capitation:							76439569.15
Total Estimated Unduplicated Participants:							14345
Factor D (Divide total by number of participants):							36056.53
Services included in capitation:							30727.88
Services not included in capitation:							5328.66
Average Length of Stay on the Waiver:							353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services Total:							3584123.44
Financial Management Services		Month	222	9.59	182.31	388134.34	
Financial Management Services - FFS		Month	1828	9.59	182.31	3195989.10	
Independent Support Broker Total:							354460.78
Independent Support Broker		Month	222	9.59	18.03	38385.51	
Independent Support Broker - FFS		Month	1828	9.59	18.03	316075.28	
Individual Directed Goods and Services Total:							1105453.69
Individual Directed Goods and Services		Month	222	9.59	56.23	119712.55	
Individual Directed Goods and Services - FFS		Month	1828	9.59	56.23	985741.14	
Self Directed Community Support and Employment Total:							15880747.51
Self Directed Community Support and Employment		Month	222	9.59	807.79	1719768.75	
Self Directed Community Support and Employment - FFS		Month	1828	9.59	807.79	14160978.75	
Self Directed Personal Care Total:							14761532.17
Self Directed Personal Care		Month	222	9.59	750.86	1598565.92	
Self Directed Personal Care - FFS		Month	1828	9.59	750.86	13162966.25	
Consumer Directed							783755.86
GRAND TOTAL:							517230940.01
Total: Services included in capitation:							440791370.86
Total: Services not included in capitation:							76439569.15
Total Estimated Unduplicated Participants:							14345
Factor D (Divide total by number of participants):							36056.53
Services included in capitation:							30727.88
Services not included in capitation:							5328.66
Average Length of Stay on the Waiver:							353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care (CDAC) - skilled Total:							
CDAC - Individual - 15 Minutes		15 Minutes	31	4389.30	3.67	499370.66	
CDAC - Agency - 15 Minutes		15 Minutes	21	1195.82	5.52	138619.45	
CDAC - Individual - 15 Minutes - FFS		15 Minutes	7	4389.30	3.67	112761.12	
CDAC - Agency - 15 Minutes - FFS		15 Minutes	5	1195.82	5.52	33004.63	
Consumer Directed Attendant Care (CDAC) - unskilled Total:							6929959.52
CDAC- Individual - 15 Minutes		15 Minutes	273	4389.30	3.67	4397683.56	
CDAC- Agency - 15 Minutes		15 Minutes	182	1195.82	5.52	1201368.60	
CDAC- Individual - 15 Minutes - FFS		15 Minutes	65	4389.30	3.67	1047067.52	
CDAC- Agency - 15 Minutes - FFS		15 Minutes	43	1195.82	5.52	283839.84	
Home and Vehicle Modification Total:							143070.91
Home and Vehicle Modifications		Occurrence	42	1.02	2337.76	100149.64	
Home and Vehicle Modifications - FFS		Occurrence	18	1.02	2337.76	42921.27	
Interim Medical Monitoring and Treatment Total:							459823.82
IMMT - Nurse		15 Minutes	0	2720.00	8.71	0.00	
IMMT - Aide or CNA		15 Minutes	16	1824.67	7.03	205238.88	
IMMT -						23691.20	
GRAND TOTAL:							517230940.01
Total: Services included in capitation:							440791370.86
Total: Services not included in capitation:							76439569.15
Total Estimated Unduplicated Participants:							14345
Factor D (Divide total by number of participants):							36056.53
Services included in capitation:							30727.88
Services not included in capitation:							5328.66
Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nurse - FFS		15 Minutes	1	2720.00	8.71		
IMMT - Aide or CNA - FFS		15 Minutes	18	1824.67	7.03	230893.74	
Personal Emergency Response or Portable Locator System Total:							126725.66
Personal Emergency Response-Ongoing		Installation	222	10.52	45.02	105141.51	
Personal Emergency Response-Initial		Installation	60	1.00	226.25	13575.00	
Personal Emergency Response-Ongoing - FFS		Installation	15	10.52	45.02	7104.16	
Personal Emergency Response-Initial - FFS		Installation	4	1.00	226.25	905.00	
Supported Community Living Total:							359887684.40
Supported Community Living, Per Day		Day	4548	323.27	194.36	285754283.75	
Supported Community Living, 15 Minutes		15 Minutes	5148	1038.78	8.31	44438883.75	
Supported Community Living, Per Day - FFS		Day	409	323.27	194.36	25697779.69	
Supported Community Living, 15 Minutes - FFS		15 Minutes	463	1038.78	8.31	3996737.21	
Transportation Total:							14158545.10
Per Trip		Trip	3118	1098.90	2.53	8668716.61	
Per Mile		Mile	1456	3873.13	0.63	3552744.69	
Per Trip - FFS		Trip	494	1098.90	2.53	1373427.20	
GRAND TOTAL:							517230940.01
Total: Services included in capitation:							440791370.86
Total: Services not included in capitation:							76439569.15
Total Estimated Unduplicated Participants:							14345
Factor D (Divide total by number of participants):							36056.53
Services included in capitation:							30727.88
Services not included in capitation:							5328.66
Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Per Mile - FFS		Mile	231	3873.13	0.63	563656.61	
GRAND TOTAL:							517230940.01
Total: Services included in capitation:							440791370.86
Total: Services not included in capitation:							76439569.15
Total Estimated Unduplicated Participants:							14345
Factor D (Divide total by number of participants):							36056.53
Services included in capitation:							30727.88
Services not included in capitation:							5328.66
Average Length of Stay on the Waiver:							353

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							4435796.79
Adult Day Care-Full Day		Day	382	130.87	68.41	3419975.98	
Adult Day Care-Half Day		Half Day	248	68.29	35.73	605120.42	
Adult Day Care - 15 Minutes		15 Minutes	5	1245.33	4.32	26899.13	
Adult Day Care-Full Day - FFS		Day	36	130.87	68.41	322301.40	
Adult Day Care-Half Day - FFS		Half Day	23	68.29	35.73	56120.04	
Adult Day Care - 15 Minutes - FFS		15 Minutes	1	1245.33	4.32	5379.83	
Day Habilitation Total:							45966978.57
Day Habilitation,		Day	3979	102.59	78.21	31925760.76	
GRAND TOTAL:							542206952.66
Total: Services included in capitation:							462342026.71
Total: Services not included in capitation:							79864925.95
Total Estimated Unduplicated Participants:							14488
Factor D (Divide total by number of participants):							37424.55
Services included in capitation:							31912.07
Services not included in capitation:							5512.49
Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ID Waiver, Per Day							
Day Habilitation, ID Waiver, 15 Minutes		15 Minutes	3253	1047.86	2.67	9101198.51	
Day Habilitation, ID Waiver, Per Day - FFS		Day	479	102.59	78.21	3843287.11	
Day Habilitation, ID Waiver, 15 Minutes - FFS		15 Minutes	392	1047.86	2.67	1096732.19	
Prevocational Services Total:							17630310.69
Prevocational Service, full day		Day	1680	110.52	63.58	11805127.49	
Prevocational Service, hour		Hour	1493	69.23	37.48	3873947.42	
Prevocational Service, full day - FFS		Day	209	110.52	63.58	1468614.07	
Prevocational Service, hour - FFS		Hour	186	69.23	37.48	482621.71	
Residential Based Supported Community Living Total:							3140567.47
Residential Based Supported Community living - day		Day	50	192.89	296.03	2855061.34	
Residential Based Supported Community living - day - FFS		Day	5	192.89	296.03	285506.13	
Respite Total:							12130072.03
Respite Resident Camp-Weeklong		15 Minutes	290	130.28	5.00	188906.00	
Respite-RCF/ID		15 Minutes	1	204.00	3.97	809.88	
Respite-HHA Specialized		15 Minutes	2	558.00	11.64	12990.24	
GRAND TOTAL:						542206952.66	
Total: Services included in capitation:						462342026.71	
Total: Services not included in capitation:						79864925.95	
Total Estimated Unduplicated Participants:						14488	
Factor D (Divide total by number of participants):						37424.55	
Services included in capitation:						31912.07	
Services not included in capitation:						5512.49	
Average Length of Stay on the Waiver:							353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite-ICF/ID		15 Minutes	2	170.67	3.91	1334.64	
Teen Day Camp - 13 to 21 Years Old		15 Minutes	6	755.00	3.95	17893.50	
Group Specialized Summer Day Camp		15 Minutes	66	137.40	11.55	104740.02	
Respite-Homa Care Agency & Non-Facility, Group		15 Minutes	1063	584.83	3.64	2262894.42	
Respite-Homa Care Agency & Non-Facility, Basic Individual		15 Minutes	2582	593.71	4.27	6545735.87	
Respite-Homa Care Agency & Non-Facility, Specialized		15 Minutes	11	772.67	9.90	84143.76	
Respite-Camp		15 Minutes	221	689.16	3.28	499558.30	
Respite-HHA Basic Individual		15 Minutes	2	828.00	5.38	8909.28	
Group Summer Day Camp - Group Recreational		15 Minutes	14	687.20	3.95	38002.16	
Respite-Nursing Facility		15 Minutes	1	528.00	3.69	1948.32	
Respite Resident Camp-Weeklong - FFS		15 Minutes	70	130.28	5.00	45598.00	
Respite-RCF/ID - FFS		15 Minutes	0	204.00	3.97	0.00	
Respite-HHA Specialized - FFS		15 Minutes	0	558.00	11.64	0.00	
Respite-ICF/ID - FFS		15 Minutes	1	170.67	3.91	667.32	
Teen Day Camp - 13 to 21 Years Old - FFS		15 Minutes	2	755.00	3.95	5964.50	
GRAND TOTAL:						542206952.66	
<i>Total: Services included in capitation:</i>						462342026.71	
<i>Total: Services not included in capitation:</i>						79864925.95	
Total Estimated Unduplicated Participants:						14488	
Factor D (Divide total by number of participants):						37424.55	
<i>Services included in capitation:</i>						31912.07	
<i>Services not included in capitation:</i>						5512.49	
Average Length of Stay on the Waiver:							353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Specialized Summer Day Camp - FFS		15 Minutes	16	137.40	11.55	25391.52	
Respite- Homa Care Agency & Non-Facility, Group - FFS		15 Minutes	258	584.83	3.64	549225.55	
Respite- Homa Care Agency & Non-Facility, Basic Individual - FFS		15 Minutes	625	593.71	4.27	1584463.56	
Respite- Homa Care Agency & Non-Facility, Specialized - FFS		15 Minutes	3	772.67	9.90	22948.30	
Respite-Camp - FFS		15 Minutes	53	689.16	3.28	119803.57	
Respite-HHA Basic Individual - FFS		15 Minutes	0	828.00	5.38	0.00	
Group Summer Day Camp - Group Recreational - FFS		15 Minutes	3	687.20	3.95	8143.32	
Respite- Nursing Facility - FFS		15 Minutes	0	528.00	3.69	0.00	
Supported Employment Total:							19581441.17
Maintain Employment - Individual		15 Minutes	673	18.12	68.98	841194.54	
Maintain Employment - Small Group		15 Minutes	843	1102.77	2.96	2751719.93	
Long Term Job Coaching		Month	2835	4.28	1174.80	14254788.24	
Maintain Employment - Individual - FFS		15 Minutes	39	18.12	68.98	48746.79	
Maintain Employment - Small Group - FFS		15 Minutes	108	1102.77	2.96	352533.51	
GRAND TOTAL:						542206952.66	
Total: Services included in capitation:						462342026.71	
Total: Services not included in capitation:						79864925.95	
Total Estimated Unduplicated Participants:						14488	
Factor D (Divide total by number of participants):						37424.55	
Services included in capitation:						31912.07	
Services not included in capitation:						5512.49	
Average Length of Stay on the Waiver:							353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Long Term Job Coaching - FFS		Month	265	4.28	1174.80	1332458.16	
Home Health Aide Services Total:							206025.97
Home Health Aide Services		Hour	34	24.97	217.13	184339.03	
Home Health Aide Services - FFS		Hour	4	24.97	217.13	21686.94	
Nursing Total:							32482.80
Nursing Care in the Home/LPN; Per Hour		Visit	15	12.00	25.78	4640.40	
Nursing Care in the Home/RN; Per Hour		Visit	5	12.00	25.78	1546.80	
Nursing Care in the Home/LPN; Per Hour - FFS		Visit	65	12.00	25.78	20108.40	
Nursing Care in the Home/RN; Per Hour - FFS		Visit	20	12.00	25.78	6187.20	
Financial Management Services Total:							3728998.23
Financial Management Services		Month	227	9.59	185.96	404821.90	
Financial Management Services - FFS		Month	1864	9.59	185.96	3324176.33	
Independent Support Broker Total:							368768.97
Independent Support Broker		Month	227	9.59	18.39	40033.74	
Independent Support Broker - FFS		Month	1864	9.59	18.39	328735.23	
Individual Directed Goods and Services Total:							1150222.30
Individual Directed		Month				124868.70	
GRAND TOTAL:						542206952.66	
Total: Services included in capitation:						462342026.71	
Total: Services not included in capitation:						79864925.95	
Total Estimated Unduplicated Participants:						14488	
Factor D (Divide total by number of participants):						37424.55	
Services included in capitation:						31912.07	
Services not included in capitation:						5512.49	
Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goods and Services			227	9.59	57.36		
Individual Directed Goods and Services - FFS		Month	1864	9.59	57.36	1025353.59	
Self Directed Community Support and Employment Total:							16522413.93
Self Directed Community Support and Employment		Month	227	9.59	823.95	1793681.47	
Self Directed Community Support and Employment - FFS		Month	1864	9.59	823.95	14728732.45	
Self Directed Personal Care Total:							15357954.22
Self Directed Personal Care		Month	227	9.59	765.88	1667267.15	
Self Directed Personal Care - FFS		Month	1864	9.59	765.88	13690687.07	
Consumer Directed Attendant Care (CDAC) - skilled Total:							800519.38
CDAC - Individual - 15 Minutes		15 Minutes	31	4389.30	3.75	510256.12	
CDAC - Agency - 15 Minutes		15 Minutes	21	1195.82	5.63	141381.80	
CDAC - Individual - 15 Minutes - FFS		15 Minutes	7	4389.30	3.75	115219.12	
CDAC - Agency - 15 Minutes - FFS		15 Minutes	5	1195.82	5.63	33662.33	
Consumer Directed Attendant Care (CDAC) - unskilled Total:							7227124.19
CDAC- Individual - 15 Minutes		15 Minutes	279	4389.30	3.75	4592305.12	
GRAND TOTAL:							542206952.66
Total: Services included in capitation:							462342026.71
Total: Services not included in capitation:							79864925.95
Total Estimated Unduplicated Participants:							14488
Factor D (Divide total by number of participants):							37424.55
Services included in capitation:							31912.07
Services not included in capitation:							5512.49
Average Length of Stay on the Waiver:							353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CDAC- Agency - 15 Minutes		15 Minutes	186	1195.82	5.63	1252238.79	
CDAC- Individual - 15 Minutes - FFS		15 Minutes	66	4389.30	3.75	1086351.75	
CDAC- Agency - 15 Minutes - FFS		15 Minutes	44	1195.82	5.63	296228.53	
Home and Vehicle Modification Total:							148364.21
Home and Vehicle Modifications		Occurrence	42	1.02	2384.51	102152.41	
Home and Vehicle Modifications - FFS		Occurrence	19	1.02	2384.51	46211.80	
Interim Medical Monitoring and Treatment Total:							468998.85
IMMT - Nurse		15 Minutes	0	2720.00	8.89	0.00	
IMMT - Aide or CNA		15 Minutes	16	1824.67	7.17	209326.14	
IMMT - Nurse - FFS		15 Minutes	1	2720.00	8.89	24180.80	
IMMT - Aide or CNA - FFS		15 Minutes	18	1824.67	7.17	235491.91	
Personal Emergency Response or Portable Locator System Total:							131652.71
Personal Emergency Response- Ongoing		Installation	225	10.52	45.92	108692.64	
Personal Emergency Response- Initial		Installation	62	1.00	230.77	14307.74	
Personal Emergency Response- Ongoing - FFS		Installation	16	10.52	45.92	7729.25	
Personal Emergency Response- Initial - FFS		Installation	4	1.00	230.77	923.08	
GRAND TOTAL:						542206952.66	
<i>Total: Services included in capitation:</i>						462342026.71	
<i>Total: Services not included in capitation:</i>						79864925.95	
<i>Total Estimated Unduplicated Participants:</i>						14488	
<i>Factor D (Divide total by number of participants):</i>						37424.55	
<i>Services included in capitation:</i>						31912.07	
<i>Services not included in capitation:</i>						5512.49	
<i>Average Length of Stay on the Waiver:</i>							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Community Living Total:							378322144.17
Supported Community Living, Per Day		Day	4687	323.27	198.25	300381756.64	
Supported Community Living, 15 Minutes		15 Minutes	5308	1038.78	8.48	46757399.16	
Supported Community Living, Per Day - FFS		Day	421	323.27	198.25	26981164.83	
Supported Community Living, 15 Minutes - FFS		15 Minutes	477	1038.78	8.48	4201823.55	
Transportation Total:							14856115.99
Per Trip		Trip	3188	1098.90	2.58	9038496.46	
Per Mile		Mile	1503	3873.13	0.65	3783854.35	
Per Trip - FFS		Trip	506	1098.90	2.58	1434591.97	
Per Mile - FFS		Mile	238	3873.13	0.65	599173.21	
GRAND TOTAL:							542206952.66
<i>Total: Services included in capitation:</i>							462342026.71
<i>Total: Services not included in capitation:</i>							79864925.95
<i>Total Estimated Unduplicated Participants:</i>							14488
<i>Factor D (Divide total by number of participants):</i>							37424.55
<i>Services included in capitation:</i>							31912.07
<i>Services not included in capitation:</i>							5512.49
<i>Average Length of Stay on the Waiver:</i>							353

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							4624030.30
Adult Day Care-Full Day		Day	390	130.87	69.77	3561011.96	
Adult Day Care-Half Day		Half Day	252	68.29	36.44	627098.88	
Adult Day Care - 15 Minutes		15 Minutes	6	1245.33	4.40	32876.71	
Adult Day Care-Full Day - FFS		Day	37	130.87	69.77	337839.60	
Adult Day Care-Half Day - FFS		Half Day	24	68.29	36.44	59723.70	
Adult Day Care - 15 Minutes - FFS		15 Minutes	1	1245.33	4.40	5479.45	
Day Habilitation Total:							47832471.16
Day Habilitation, ID Waiver, Per Day		Day	4058	102.59	79.77	33209066.25	
Day Habilitation, ID Waiver, 15 Minutes		15 Minutes	3314	1047.86	2.73	9480219.95	
Day Habilitation, ID Waiver, Per Day - FFS		Day	489	102.59	79.77	4001782.50	
Day Habilitation, ID Waiver, 15 Minutes - FFS		15 Minutes	399	1047.86	2.73	1141402.46	
Prevocational Services Total:							18343784.43
Prevocational Service, full day		Day	1714	110.52	64.85	12284618.51	
Prevocational Service, hour		Hour	1524	69.23	38.22	4032459.19	
Prevocational Service, full day - FFS		Day	213	110.52	64.85	1526618.29	
Prevocational Service, hour - FFS		Hour	189	69.23	38.22	500088.44	
Residential							3261615.59
GRAND TOTAL:							559741722.92
Total: Services included in capitation:							476976321.76
Total: Services not included in capitation:							82765401.17
Total Estimated Unduplicated Participants:							14633
Factor D (Divide total by number of participants):							38252.01
Services included in capitation:							32595.94
Services not included in capitation:							5656.08
Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Based Supported Community Living Total:							
Residential Based Supported Community living - day		Day	51	192.89	301.95	2970399.91	
Residential Based Supported Community living - day - FFS		Day	5	192.89	301.95	291215.68	
Respite Total:							12602472.76
Respite Resident Camp-Weeklong		15 Minutes	295	130.28	5.10	196006.26	
Respite-RCF/ID		15 Minutes	1	204.00	4.05	826.20	
Respite-HHA Specialized		15 Minutes	2	558.00	11.87	13246.92	
Respite-ICF/ID		15 Minutes	2	170.67	3.99	1361.95	
Teen Day Camp - 13 to 21 Years Old		15 Minutes	6	755.00	4.03	18255.90	
Group Specialized Summer Day Camp		15 Minutes	68	137.40	11.78	110062.90	
Respite-Homa Care Agency & Non-Facility, Group		15 Minutes	1085	584.83	3.71	2354145.44	
Respite-Homa Care Agency & Non-Facility, Basic Individual		15 Minutes	2633	593.71	4.35	6800087.17	
Respite-Homa Care Agency & Non-Facility, Specialized		15 Minutes	11	772.67	10.10	85843.64	
Respite-Camp		15 Minutes	225	689.16	3.34	517903.74	
Respite-HHA Basic Individual		15 Minutes	2	828.00	5.49	9091.44	
GRAND TOTAL:						559741722.92	
Total: Services included in capitation:						476976321.76	
Total: Services not included in capitation:						82765401.17	
Total Estimated Unduplicated Participants:						14633	
Factor D (Divide total by number of participants):						38252.01	
Services included in capitation:						32595.94	
Services not included in capitation:						5656.08	
Average Length of Stay on the Waiver:							353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Summer Day Camp - Group Recreational		15 Minutes	14	687.20	4.03	38771.82	
Respite- Nursing Facility		15 Minutes	1	528.00	3.77	1990.56	
Respite Resident Camp- Weeklong - FFS		15 Minutes	72	130.28	5.10	47838.82	
Respite- RCF/ID - FFS		15 Minutes	0	204.00	4.05	0.00	
Respite-HHA Specialized - FFS		15 Minutes	0	558.00	11.87	0.00	
Respite- ICF/ID - FFS		15 Minutes	1	170.67	3.99	680.97	
Teen Day Camp - 13 to 21 Years Old - FFS		15 Minutes	2	755.00	4.03	6085.30	
Group Specialized Summer Day Camp - FFS		15 Minutes	16	137.40	11.78	25897.15	
Respite- Homa Care Agency & Non-Facility, Group - FFS		15 Minutes	263	584.83	3.71	570636.18	
Respite- Homa Care Agency & Non-Facility, Basic Individual - FFS		15 Minutes	638	593.71	4.35	1647723.36	
Respite- Homa Care Agency & Non-Facility, Specialized - FFS		15 Minutes	3	772.67	10.10	23411.90	
Respite-Camp - FFS		15 Minutes	54	689.16	3.34	124296.90	
Respite-HHA Basic Individual - FFS		15 Minutes	0	828.00	5.49	0.00	
Group Summer Day Camp - Group		15 Minutes	3	687.20	4.03	8308.25	
GRAND TOTAL:						559741722.92	
<i>Total: Services included in capitation:</i>						476976321.76	
<i>Total: Services not included in capitation:</i>						82765401.17	
<i>Total Estimated Unduplicated Participants:</i>						14633	
<i>Factor D (Divide total by number of participants):</i>						38252.01	
<i>Services included in capitation:</i>						32595.94	
<i>Services not included in capitation:</i>						5656.08	
<i>Average Length of Stay on the Waiver:</i>							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Recreational - FFS							
Respite-Nursing Facility - FFS		15 Minutes	0	528.00	3.77	0.00	
Supported Employment Total:							20362241.77
Maintain Employment - Individual		15 Minutes	686	18.12	70.36	874597.32	
Maintain Employment - Small Group		15 Minutes	860	1102.77	3.01	2854630.42	
Long Term Job Coaching		Month	2892	4.28	1198.29	14832146.03	
Maintain Employment - Individual - FFS		15 Minutes	40	18.12	70.36	50996.93	
Maintain Employment - Small Group - FFS		15 Minutes	110	1102.77	3.01	365127.15	
Long Term Job Coaching - FFS		Month	270	4.28	1198.29	1384743.92	
Home Health Aide Services Total:							215674.13
Home Health Aide Services		Hour	35	24.97	221.47	193553.71	
Home Health Aide Services - FFS		Hour	4	24.97	221.47	22120.42	
Nursing Total:							33769.20
Nursing Care in the Home/LPN; Per Hour		Visit	16	12.00	26.30	5049.60	
Nursing Care in the Home/RN; Per Hour		Visit	5	12.00	26.30	1578.00	
Nursing Care in the Home/LPN; Per Hour - FFS		Visit	66	12.00	26.30	20829.60	
Nursing Care in the Home/RN; Per Hour - FFS		Visit	20	12.00	26.30	6312.00	
GRAND TOTAL:							559741722.92
Total: Services included in capitation:							476976321.76
Total: Services not included in capitation:							82765401.17
Total Estimated Unduplicated Participants:							14633
Factor D (Divide total by number of participants):							38252.01
Services included in capitation:							32595.94
Services not included in capitation:							5656.08
Average Length of Stay on the Waiver:							353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services Total:							3879993.55
Financial Management Services		Month	231	9.59	189.68	420196.21	
Financial Management Services - FFS		Month	1902	9.59	189.68	3459797.34	
Independent Support Broker Total:							383744.62
Independent Support Broker		Month	231	9.59	18.76	41558.84	
Independent Support Broker - FFS		Month	1902	9.59	18.76	342185.78	
Individual Directed Goods and Services Total:							1196645.00
Individual Directed Goods and Services		Month	231	9.59	58.50	129594.46	
Individual Directed Goods and Services - FFS		Month	1902	9.59	58.50	1067050.53	
Self Directed Community Support and Employment Total:							17191186.10
Self Directed Community Support and Employment		Month	231	9.59	840.42	1861774.02	
Self Directed Community Support and Employment - FFS		Month	1902	9.59	840.42	15329412.08	
Self Directed Personal Care Total:							15979813.16
Self Directed Personal Care		Month	231	9.59	781.20	1730584.55	
Self Directed Personal Care - FFS		Month	1902	9.59	781.20	14249228.62	
Consumer Directed							839246.10
GRAND TOTAL:							559741722.92
Total: Services included in capitation:							476976321.76
Total: Services not included in capitation:							82765401.17
Total Estimated Unduplicated Participants:							14633
Factor D (Divide total by number of participants):							38252.01
Services included in capitation:							32595.94
Services not included in capitation:							5656.08
Average Length of Stay on the Waiver:							353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care (CDAC) - skilled Total:							
CDAC - Individual - 15 Minutes		15 Minutes	31	4389.30	3.82	519780.91	
CDAC - Agency - 15 Minutes		15 Minutes	22	1195.82	5.74	151008.15	
CDAC - Individual - 15 Minutes - FFS		15 Minutes	8	4389.30	3.82	134137.01	
CDAC - Agency - 15 Minutes - FFS		15 Minutes	5	1195.82	5.74	34320.03	
Consumer Directed Attendant Care (CDAC) - unskilled Total:							7498302.82
CDAC- Individual - 15 Minutes		15 Minutes	283	4389.30	3.82	4745096.66	
CDAC- Agency - 15 Minutes		15 Minutes	190	1195.82	5.74	1304161.29	
CDAC- Individual - 15 Minutes - FFS		15 Minutes	68	4389.30	3.82	1140164.57	
CDAC- Agency - 15 Minutes - FFS		15 Minutes	45	1195.82	5.74	308880.31	
Home and Vehicle Modification Total:							156293.17
Home and Vehicle Modifications		Occurrence	44	1.02	2432.20	109157.14	
Home and Vehicle Modifications - FFS		Occurrence	19	1.02	2432.20	47136.04	
Interim Medical Monitoring and Treatment Total:							491485.02
IMMT - Nurse		15 Minutes	0	2720.00	9.06	0.00	
IMMT - Aide or CNA		15 Minutes	17	1824.67	7.31	226751.74	
IMMT -						24643.20	
GRAND TOTAL:						559741722.92	
Total: Services included in capitation:						476976321.76	
Total: Services not included in capitation:						82765401.17	
Total Estimated Unduplicated Participants:						14633	
Factor D (Divide total by number of participants):						38252.01	
Services included in capitation:						32595.94	
Services not included in capitation:						5656.08	
Average Length of Stay on the Waiver:						353	

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nurse - FFS		15 Minutes	1	2720.00	9.06		
IMMT - Aide or CNA - FFS		15 Minutes	18	1824.67	7.31	240090.08	
Personal Emergency Response or Portable Locator System Total:							136991.30
Personal Emergency Response-Ongoing		Installation	230	10.52	46.84	113334.06	
Personal Emergency Response-Initial		Installation	63	1.00	235.39	14829.57	
Personal Emergency Response-Ongoing - FFS		Installation	16	10.52	46.84	7884.11	
Personal Emergency Response-Initial - FFS		Installation	4	1.00	235.89	943.56	
Supported Community Living Total:							389365910.80
Supported Community Living, Per Day		Day	4729	323.27	202.21	309127289.86	
Supported Community Living, 15 Minutes		15 Minutes	5356	1038.78	8.65	48126054.13	
Supported Community Living, Per Day - FFS		Day	425	323.27	202.21	27781581.35	
Supported Community Living, 15 Minutes - FFS		15 Minutes	482	1038.78	8.65	4330985.45	
Transportation Total:							15346051.95
Per Trip		Trip	3244	1098.90	2.63	9375507.11	
Per Mile		Mile	1515	3873.13	0.66	3872742.69	
Per Trip - FFS		Trip	514	1098.00	2.63	1484298.36	
GRAND TOTAL:							559741722.92
Total: Services included in capitation:							476976321.76
Total: Services not included in capitation:							82765401.17
Total Estimated Unduplicated Participants:							14633
Factor D (Divide total by number of participants):							38252.01
Services included in capitation:							32595.94
Services not included in capitation:							5656.08
Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Per Mile - FFS		Mile	240	3873.13	0.66	613503.79	
GRAND TOTAL:						559741722.92	
Total: Services included in capitation:						476976321.76	
Total: Services not included in capitation:						82765401.17	
Total Estimated Unduplicated Participants:						14633	
Factor D (Divide total by number of participants):						38252.01	
Services included in capitation:						32595.94	
Services not included in capitation:						5656.08	
Average Length of Stay on the Waiver:							353

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							4806550.19
Adult Day Care-Full Day		Day	398	130.87	71.17	3706979.12	
Adult Day Care-Half Day		Half Day	258	68.29	37.17	654891.54	
Adult Day Care - 15 Minutes		15 Minutes	6	1245.33	4.49	33549.19	
Adult Day Care-Full Day - FFS		Day	37	130.87	71.17	344618.66	
Adult Day Care-Half Day - FFS		Half Day	24	68.29	37.17	60920.14	
Adult Day Care - 15 Minutes - FFS		15 Minutes	1	1245.33	4.49	5591.53	
Day Habilitation Total:							49748579.99
Day Habilitation,		Day	4140	102.59	81.37	34559677.96	
GRAND TOTAL:						582995334.70	
Total: Services included in capitation:						496816557.68	
Total: Services not included in capitation:						86178777.02	
Total Estimated Unduplicated Participants:						14780	
Factor D (Divide total by number of participants):						39444.88	
Services included in capitation:						33614.11	
Services not included in capitation:						5830.77	
Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ID Waiver, Per Day							
Day Habilitation, ID Waiver, 15 Minutes		15 Minutes	3380	1047.86	2.78	9846111.70	
Day Habilitation, ID Waiver, Per Day - FFS		Day	498	102.59	81.37	4157178.65	
Day Habilitation, ID Waiver, 15 Minutes - FFS		15 Minutes	407	1047.86	2.78	1185611.68	
Prevocational Services Total:							19081552.71
Prevocational Service, full day		Day	1748	110.52	66.15	12779449.70	
Prevocational Service, hour		Hour	1554	69.23	38.99	4194677.55	
Prevocational Service, full day - FFS		Day	217	110.52	66.15	1586464.87	
Prevocational Service, hour - FFS		Hour	193	69.23	38.99	520960.60	
Residential Based Supported Community Living Total:							3386156.95
Residential Based Supported Community living - day		Day	52	192.89	307.98	3089125.63	
Residential Based Supported Community living - day - FFS		Day	5	192.89	307.98	297031.31	
Respite Total:							13074697.46
Respite Resident Camp-Weeklong		15 Minutes	302	130.28	5.21	204985.16	
Respite-RCF/ID		15 Minutes	1	204.00	4.13	842.52	
Respite-HHA Specialized		15 Minutes	2	558.00	12.11	13514.76	
GRAND TOTAL:						582995334.70	
Total: Services included in capitation:						496816557.68	
Total: Services not included in capitation:						86178777.02	
Total Estimated Unduplicated Participants:						14780	
Factor D (Divide total by number of participants):						39444.88	
Services included in capitation:						33614.11	
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Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite-ICF/ID		15 Minutes	2	170.67	4.07	1389.25	
Teen Day Camp - 13 to 21 Years Old		15 Minutes	7	755.00	4.11	21721.35	
Group Specialized Summer Day Camp		15 Minutes	69	137.40	12.01	113862.01	
Respite-Homa Care Agency & Non-Facility, Group		15 Minutes	1107	584.83	3.73	2414827.40	
Respite-Homa Care Agency & Non-Facility, Basic Individual		15 Minutes	2685	593.71	4.44	7077854.39	
Respite-Homa Care Agency & Non-Facility, Specialized		15 Minutes	11	772.67	10.30	87543.51	
Respite-Camp		15 Minutes	229	689.16	3.41	538158.15	
Respite-HHA Basic Individual		15 Minutes	2	828.00	5.60	9273.60	
Group Summer Day Camp - Group Recreational		15 Minutes	14	687.20	4.11	39541.49	
Respite-Nursing Facility		15 Minutes	1	528.00	3.84	2027.52	
Respite Resident Camp-Weeklong - FFS		15 Minutes	73	130.28	5.21	49549.39	
Respite-RCF/ID - FFS		15 Minutes	0	204.00	4.13	0.00	
Respite-HHA Specialized - FFS		15 Minutes	0	558.00	12.11	0.00	
Respite-ICF/ID - FFS		15 Minutes	1	170.67	4.07	694.63	
Teen Day Camp - 13 to 21 Years Old - FFS		15 Minutes	2	755.00	4.11	6206.10	
GRAND TOTAL:						582995334.70	
<i>Total: Services included in capitation:</i>						<i>496816557.68</i>	
<i>Total: Services not included in capitation:</i>						<i>86178777.02</i>	
Total Estimated Unduplicated Participants:						14780	
Factor D (Divide total by number of participants):						39444.88	
<i>Services included in capitation:</i>						<i>33614.11</i>	
<i>Services not included in capitation:</i>						<i>5830.77</i>	
Average Length of Stay on the Waiver:						353	

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Specialized Summer Day Camp - FFS		15 Minutes	17	137.40	12.01	28052.96	
Respite- Homa Care Agency & Non-Facility, Group - FFS		15 Minutes	268	584.83	3.73	584619.46	
Respite- Homa Care Agency & Non-Facility, Basic Individual - FFS		15 Minutes	651	593.71	4.44	1716083.13	
Respite- Homa Care Agency & Non-Facility, Specialized - FFS		15 Minutes	3	772.67	10.30	23875.50	
Respite-Camp - FFS		15 Minutes	56	689.16	3.41	131601.99	
Respite-HHA Basic Individual - FFS		15 Minutes	0	828.00	5.60	0.00	
Group Summer Day Camp - Group Recreational - FFS		15 Minutes	3	687.20	4.11	8473.18	
Respite- Nursing Facility - FFS		15 Minutes	0	528.00	3.84	0.00	
Supported Employment Total:							21186698.99
Maintain Employment - Individual		15 Minutes	700	18.12	71.77	910330.68	
Maintain Employment - Small Group		15 Minutes	877	1102.77	3.07	2969086.92	
Long Term Job Coaching		Month	2950	4.28	1222.26	15432254.76	
Maintain Employment - Individual - FFS		15 Minutes	40	18.12	71.77	52018.90	
Maintain Employment - Small Group - FFS		15 Minutes	112	1102.77	3.07	379176.44	
GRAND TOTAL:							582995334.70
Total: Services included in capitation:							496816557.68
Total: Services not included in capitation:							86178777.02
Total Estimated Unduplicated Participants:							14780
Factor D (Divide total by number of participants):							39444.88
Services included in capitation:							33614.11
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Average Length of Stay on the Waiver:							353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Long Term Job Coaching - FFS		Month	276	4.28	1222.26	1443831.29	
Home Health Aide Services Total:							225628.92
Home Health Aide Services		Hour	36	24.97	225.90	203066.03	
Home Health Aide Services - FFS		Hour	4	24.97	225.90	22562.89	
Nursing Total:							35080.56
Nursing Care in the Home/LPN; Per Hour		Visit	16	12.00	26.82	5149.44	
Nursing Care in the Home/RN; Per Hour		Visit	5	12.00	26.82	1609.20	
Nursing Care in the Home/LPN; Per Hour - FFS		Visit	67	12.00	26.82	21563.28	
Nursing Care in the Home/RN; Per Hour - FFS		Visit	21	12.00	26.82	6758.64	
Financial Management Services Total:							4037301.00
Financial Management Services		Month	236	9.59	193.47	437869.04	
Financial Management Services - FFS		Month	1940	9.59	193.47	3599431.96	
Independent Support Broker Total:							399410.46
Independent Support Broker		Month	236	9.59	19.14	43318.41	
Independent Support Broker - FFS		Month	1940	9.59	19.14	356092.04	
Individual Directed Goods and Services Total:							1245184.01
Individual Directed		Month				135047.53	
GRAND TOTAL:							582995334.70
Total: Services included in capitation:							496816557.68
Total: Services not included in capitation:							86178777.02
Total Estimated Unduplicated Participants:							14780
Factor D (Divide total by number of participants):							39444.88
Services included in capitation:							33614.11
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Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goods and Services			236	9.59	59.67		
Individual Directed Goods and Services - FFS		Month	1940	9.59	59.67	1110136.48	
Self Directed Community Support and Employment Total:							17888538.48
Self Directed Community Support and Employment		Month	236	9.59	857.23	1940117.23	
Self Directed Community Support and Employment - FFS		Month	1940	9.59	857.23	15948421.26	
Self Directed Personal Care Total:							16627912.27
Self Directed Personal Care		Month	236	9.59	796.82	1803394.90	
Self Directed Personal Care - FFS		Month	1940	9.59	796.82	14824517.37	
Consumer Directed Attendant Care (CDAC) - skilled Total:							873933.44
CDAC - Individual - 15 Minutes		15 Minutes	32	4389.30	3.90	547784.64	
CDAC - Agency - 15 Minutes		15 Minutes	22	1195.82	5.86	154165.11	
CDAC - Individual - 15 Minutes - FFS		15 Minutes	8	4389.30	3.90	136946.16	
CDAC - Agency - 15 Minutes - FFS		15 Minutes	5	1195.82	5.86	35037.53	
Consumer Directed Attendant Care (CDAC) - unskilled Total:							7803134.40
CDAC- Individual - 15 Minutes		15 Minutes	289	4389.30	3.90	4947180.03	
GRAND TOTAL:							582995334.70
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Total Estimated Unduplicated Participants:							14780
Factor D (Divide total by number of participants):							39444.88
Services included in capitation:							33614.11
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Average Length of Stay on the Waiver:							353

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CDAC-Agency - 15 Minutes		15 Minutes	193	1195.82	5.86	1352448.50	
CDAC-Individual - 15 Minutes - FFS		15 Minutes	69	4389.30	3.90	1181160.63	
CDAC-Agency - 15 Minutes - FFS		15 Minutes	46	1195.82	5.86	322345.24	
Home and Vehicle Modification Total:							161949.89
Home and Vehicle Modifications		Occurrence	44	1.02	2480.85	111340.55	
Home and Vehicle Modifications - FFS		Occurrence	20	1.02	2480.85	50609.34	
Interim Medical Monitoring and Treatment Total:							515166.18
IMMT - Nurse		15 Minutes	0	2720.00	9.24	0.00	
IMMT - Aide or CNA		15 Minutes	17	1824.67	7.46	231404.65	
IMMT - Nurse - FFS		15 Minutes	1	2720.00	9.24	25132.80	
IMMT - Aide or CNA - FFS		15 Minutes	19	1824.67	7.46	258628.73	
Personal Emergency Response or Portable Locator System Total:							142490.17
Personal Emergency Response-Ongoing		Installation	235	10.52	47.78	118121.72	
Personal Emergency Response-Initial		Installation	64	1.00	240.09	15365.76	
Personal Emergency Response-Ongoing - FFS		Installation	16	10.52	47.78	8042.33	
Personal Emergency Response-Initial - FFS		Installation	4	1.00	240.09	960.36	
GRAND TOTAL:						582995334.70	
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Average Length of Stay on the Waiver:							353

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Community Living Total:							405781264.27
Supported Community Living, Per Day		Day	4833	323.27	206.26	322253180.08	
Supported Community Living, 15 Minutes		15 Minutes	5460	1038.78	8.82	50024736.22	
Supported Community Living, Per Day - FFS		Day	435	323.27	206.26	29004786.54	
Supported Community Living, 15 Minutes - FFS		15 Minutes	491	1038.78	8.82	4498561.44	
Transportation Total:							15974104.36
Per Trip		Trip	3313	1098.90	2.68	9756957.28	
Per Mile		Mile	1554	3873.13	0.67	4032625.49	
Per Trip - FFS		Trip	525	1098.90	2.68	1546152.30	
Per Mile - FFS		Mile	246	3873.13	0.67	638369.29	
GRAND TOTAL:							582995334.70
<i>Total: Services included in capitation:</i>							496816557.68
<i>Total: Services not included in capitation:</i>							86178777.02
<i>Total Estimated Unduplicated Participants:</i>							14780
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