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 HHS 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.

When the Iowa legislature appropriates increases for provider agency reimbursement rates the CCO rates for waiver services are increased by the same percentage.

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 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 with determining whether a potential employee meets the qualifications necessary to perform the job.
- Assist with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

- Assist with negotiating with entities providing services and supports if requested by the member.
- Assist with contracts and payment methods for services and supports if requested by the member.
- Assist with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- Review expenditure reports from the FMS 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 with fiscal and payroll-related responsibilities including, but not limited to:
  - Verifying that hourly wages comply with federal and state labor rules.
  - Collecting and processing timecards.
  - 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.
  - Computing and processing other withholdings, as applicable.
  - Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  - Preparing and issuing employee payroll checks.
  - Preparing and disbursing IRS Forms W-2 and W-3 annually.
  - Processing federal advance earned income tax credit for eligible employees.
  - Refunding over-collected FICA, when appropriate.
  - 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 for each waiver service that can be used in the CCO program. The calculations are does 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 Iowa Medicaid 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 HHS 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 Iowa Medicaid 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 members living together and receiving HCBS services in the community. HHS 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 Iowa Medicaid 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 HHS offices, the HHS website, and has been distributed to other community agencies. The participant may also call Iowa Medicaid 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 Iowa Medicaid 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 HHS 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. HHS 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
Self Directed Community Support and Employment	☒	☒
Adult Day Care	☒	☒
Consumer Directed Attendant Care (CDAC) - unskilled	☒	☒
Supported Community Living	☒	☒
Home and Vehicle Modification	☒	☒
Prevocational Services	☒	☒
Individual Directed Goods and Services	☒	☒
Day Habilitation	☒	☒
Self Directed Personal Care	☒	☒
Consumer Directed Attendant Care (CDAC) - skilled	☒	☐
Medical Day Care for Children	☒	☒
Respite	☒	☒
Independent Support Broker	☒	☒

Waiver Service	Employer Authority	Budget Authority
Supported Employment	☒	☒
Transportation	☒	☒

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 Mangement 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 charged 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 HHS or a financial institution charted by the Office if 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.

Iowa Medicaid 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 HHS or by a designated Iowa Medicaid 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 Iowa Medicaid reviews for compliance and monitors outcomes.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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
Self Directed Community Support and Employment	☐
Adult Day Care	☐
Consumer Directed Attendant Care (CDAC) - unskilled	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supported Community Living	☐
Financial Management Services	☒
Home and Vehicle Modification	☐
Nursing	☐
Prevocational Services	☐
Individual Directed Goods and Services	☐
Day Habilitation	☐
Self Directed Personal Care	☐
Personal Emergency Response or Portable Locator System	☐
Residential Based Supported Community Living	☐
Consumer Directed Attendant Care (CDAC) - skilled	☐
Medical Day Care for Children	☐
Respite	☐
Home Health Aide Services	☐
Independent Support Broker	☒
Interim Medical Monitoring and Treatment	☐
Supported Employment	☐
Enabling Technology for Remote Support	☐
Transportation	☐

☒ **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 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 Iowa Medicaid 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 Iowa Medicaid 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)

l. 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, 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, HHS 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

E-1: Overview (13 of 13)

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		2600
Year 2		2600
Year 3		2600
Year 4		2600
Year 5		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 Iowa Medicaid where the claim is adjudicated in accordance with Iowa Medicaid 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 Health and 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.