Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

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	Case Management		
Statutory Service	Prevocational Services		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Extended State Plan Service	Specialized Medical Equipment		
Supports for Participant Direction	Financial Management Service		
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	Behavioral Programming		
Other Service	Consumer Directed Attendant Care (CDAC) unskilled		
Other Service	Consumer Directed Attendant Care - Skilled		
Other Service	Enabling Technology for Remote Support		
Other Service	Family Counseling and Training Services		
Other Service	Home and Vehicle Modification		
Other Service	Interim Medical Monitoring and Treatment (IMMT)		
Other Service	Medical Day Care for Children		
Other Service	Personal Emergency Response System 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:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult day care services provide an organized program of supportive care in a group or individual environment to persons who need a degree of supervision and assistance on regular or intermittent basis in a day care center or in the home due to the absence of the primary caregiver. Supports provided during day care would be protective oversight, supervision, ADLs and IADLs. Included are personal cares (i.e.: ambulation, toileting, feeding, medications), behavioral support, 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.

Transportation is not a required element of adult day services but if the cost of transportation is provided and charged to Medicaid, the cost of transportation must be included in the adult day health per diem.

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

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

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

Adult day services have an upper rate limit if there is no Veterans Administration contract. The upper rate limits are published in 441 IAC Chapter 79. The rates are subject to change on a yearly basis.

A unit of service is 15 minutes, a half day (1 to 4 hours), a full day (4.25 to 8 hours) or an extended day (8.25 to 12 hours). When Adult Day Care services are provided to an individual member within their home, the unit of service is a 15-minute unit and the reimbursement rate is the Adult Day Care provider's Adult Day Care rate for the 15-minute unit of service or the provider's Specialized Respite rate not to exceed the current upper rate limit for Specialized Respite in 441 IAC 79.1(2) at the time the service is delivered, whichever applies.
The total cost of Adult Day Care provided in the member's home may not exceed the current upper rate limit for Specialized Respite in 441 IAC 79.1(2) at the time the service is delivered.

Transportation is not a required element of adult day services, but when transportation is provided to and from the ADC location the cost of transportation is included in the rate paid to the ADC provider.

The case manager is responsible for authorizing services based on member need and monitors the service to assure that needed services are provided.

If transportation to and from the ADC is needed (based on the ADC providers transportation), the CM will authorize and monitor the authorized transportation as needed.

Members enrolled in the waiver have access to Iowa's Medicaid Exception to Policy option. ETPs can be requested to Iowa Administrative Code (IAC) rules but cannot be requested for Federal requirements or state law. Members needing additional services in order to ensure health, safety, or other issues can request ETPs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding ETP requests are approved by the Department of Health and Human Services director.

These 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	Respite Care providers certified under the BI or ID waivers
Agency	Adult Day Care Agencies that are certified by the Department of Inspections and Appeals
Agency	Home Health Agency certified to provide Respite
Agency	Home Care Agency certified to provide Respite
Agency	Supported Community Living providers certified under the BI or ID Waivers to provide Respite

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:

Respite Care providers certified under the BI or ID 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):*

(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:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five years

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 that are certified by the Department of Inspections and Appeals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Agency that is certified by the Department of Inspection and Appeals as being in compliance with the standards for adult day services located at 481 Iowa Adminsiateive Code - Chapter 70.

Other Standard *(specify):*

Providers must be:
(1) At least 18 years of age.
(2) Qualified by training
(3) Not the spouse or guardian of the member
(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 Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Providers are recertified every five years

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:

Home Health Agency certified to provide Respite

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):*

(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:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five years

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:

Home Care Agency certified to provide Respite

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Eligible Home care agencies are those that meet the conditions set forth in Iowa Administrative Code 441--77.33(4). a. Certified as a home health agency under Medicare, or b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number. (at this time, the IDPH is no longer contracting for homemaker services.)

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:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five years

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:

Supported Community Living providers certified under the BI or ID Waivers to provide Respite

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):*

(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:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Case Management services are activities that assist members in gaining access to needed medical, behavioral, social, and other appropriate services. Case Management is provided at the direction of the member and the interdisciplinary team.

Case Management includes:
1. Use of the comprehensive assessment of the member's needs
2. Development and implementation of a service plan to meet those needs.
3. Coordination, authorization and monitoring of all services delivery.
4. Monitoring the member's health and welfare.
5. Evaluating outcomes.
6. Periodic reassessment and revision of the service plan as needed but at least annually.
7. On going advocacy on behalf of the member.

Providers delivering this service via the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given when client needs include: accessibility, translation, or limited auditory or visual capacities are present;
•Have a contingency plan for provision of services if technology fails;
•Professionals do not practice outside of their respective scope; and
•Assessment of clients and caregivers that identifies a client's ability to participate in and outlines any accommodations needed while using Telehealth.

“Telehealth” means the delivery of services through the use of real-time interactive audio and video, or other real-time interactive electronic media, regardless of where the health care professional and the covered person are each located. “Telehealth” does not include the delivery of health care services delivered solely through an audio-only telephone, electronic mail message, or facsimile transmission.

The use of telehealth is not meant to replace the in-person supports for those individuals who require hands on or physical assistance during the service delivery.

The member’s case manager or community-based case manager is responsible for ensuring that the member has been provided the appropriate training on the use of the telehealth technology within the home including how to disable and shut off the technology.

The use of telehealth can assist individuals to live more independently and support a safe transition to independent living while enhancing their self-advocacy skills and increase opportunities for participating in the community.

Telehealth is an available service delivery modality when the member chooses to receive their services via telehealth and the service modality is clinically appropriate to the member's assessed needs.

The state works closely with the agency providers to develop and provide training and other resources on the delivery of HCBS. The state will continue to support individuals receiving HCBS through the established service monitoring activities of the Care Coordinators, Case Managers, and Community-Based Case Managers, the quality oversight activities of the HCBS QIO and providing technical assistance, information and additional resources as the need is identified.

Services delivered via telehealth will be delivered in a setting/location that protects the waiver participants privacy and therefore not permitted to be delivered in settings such as bathrooms.

In-person contact is not required as a prerequisite for payment.

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

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

Payment for FFS case management may not be made until the member is enrolled in the waiver. Payment can also only be made if case management activity is performed on behalf of the member during the month. Case Managers are required to have at least quarterly face to face contacts and monthly collateral contacts.

Providers delivering this service via the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given when client needs include: accessibility, translation, or limited auditory or visual capacities are present;
•Have a contingency plan for provision of services if technology fails;
•Professionals do not practice outside of their respective scope; and
•Assessment of clients and caregivers that identifies a client's ability to participate in and outlines any accommodations needed while using Telehealth A unit of service is 15 minutes.

These 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	Agency - HHS
Agency	Agency - Provider Chapter 24 accredited
Agency	Agency- County

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:

Agency - HHS
Provider Qualifications
License *(specify):*

Certificate *(specify):*

An Agency that meets Iowa Administrative code 441.24 for case management services. The Agency submits their certification papers along with their provider application in order to be enrolled to provide case management
An Agency or individual that is accredited through the Commission on Accreditation of Rehabilitation Facilities for Case Management services. They must attach a current certification and most recent CARF survey report

Other Standard *(specify):*

Qualified case managers and supervisors" means people who have the following qualifications:
1. A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or
2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.

) Case management services. "Case management services" means those services established pursuant to Iowa Code section 225C.20.
a. Performance benchmark. Case management services link individuals using the service to service agencies and support systems responsible for providing the necessary direct service activities and coordinate and monitor those services.
b. Performance indicators.
(1) Staff clearly define the need for case management and document it annually.
(2) At a minimum, the team is composed of the individual using the service, the case manager, and providers or natural supports relevant to the individual's service needs. The team may also include family members, at the discretion of the individual using the service.
(3) The team works with the individual using the service to establish the service plan that guides and coordinates the delivery of the services.
(4) The case manager advocates for the individual using the service.
(5) The case manager coordinates and monitors the services provided to the individual using the service.
(6) Documentation of contacts includes the date, the name of the individual using the service, the name of the case manager, and the place of service.
(7) The case manager holds individual face-to-face meetings at least quarterly with the individual using the service.
(8) Case managers do not provide direct services. Individuals using the service are linked to appropriate resources, which provide necessary direct services and natural supports.
(9) Individuals using the service participate in developing an individualized crisis intervention plan that includes natural supports and self-help methods.
(10) Documentation shows that individuals using the service are informed about their choice of providers as provided in the county management plan.
(11) Within an accredited case management program, the average caseload is no more than 45 individuals per each full-time case manager. The average caseload of children with serious emotional disturbance is no more than 15 children per full-time case manager.
(12) The case manager communicates with the team and then documents in the individual's file a quarterly review of the individual's progress toward achieving the goals

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provide Services Unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Agency - Provider Chapter 24 accredited

Provider Qualifications

License *(specify):*

An Agency that meets Iowa Administrative code 441.24 for case management services. The Agency submits their certification papers along with their provider application in order to be enrolled to provide case management

Certificate *(specify):*

Other Standard *(specify):*

"Qualified case managers and supervisors" means people who have the following qualifications:
1. A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or
2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.

) Case management services. "Case management services" means those services established pursuant to Iowa Code section 225C.20.
a. Performance benchmark. Case management services link individuals using the service to service agencies and support systems responsible for providing the necessary direct service activities and coordinate and monitor those services.
b. Performance indicators.
(1) Staff clearly define the need for case management and document it annually.
(2) At a minimum, the team is composed of the individual using the service, the case manager, and providers or natural supports relevant to the individual's service needs. The team may also include family members, at the discretion of the individual using the service.
(3) The team works with the individual using the service to establish the service plan that guides and coordinates the delivery of the services.
(4) The case manager advocates for the individual using the service.
(5) The case manager coordinates and monitors the services provided to the individual using the service.
(6) Documentation of contacts includes the date, the name of the individual using the service, the name of the case manager, and the place of service.
(7) The case manager holds individual face-to-face meetings at least quarterly with the individual using the service.
(8) Case managers do not provide direct services. Individuals using the service are linked to appropriate resources, which provide necessary direct services and natural supports.
(9) Individuals using the service participate in developing an individualized crisis intervention plan that includes natural supports and self-help methods.
(10) Documentation shows that individuals using the service are informed about their choice of providers as provided in the county management plan.
(11) Within an accredited case management program, the average caseload is no more than 45 individuals per each full-time case manager. The average caseload of children with serious emotional disturbance is no more than 15 children per full-time case manager.
(12) The case manager communicates with the team and then documents in the individual's file a quarterly review of the individual's progress toward achieving the goals

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Agency- County

Provider Qualifications

License *(specify):*

Certificate *(specify):*

An Agency that meets Iowa Administrative code 441.24 for case management services. The Agency submits their certification papers along with their provider application in order to be enrolled to provide case management

An Agency that is accredited through the Commission on Accreditation of Rehabilitation Facilities for Case Management services. They must attach a current certification and most recent CARF survey report.

Other Standard *(specify):*

Qualified case managers and supervisors" means people who have the following qualifications:
1. A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or
2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.

) Case management services. "Case management services" means those services established pursuant to Iowa Code section 225C.20.
a. Performance benchmark. Case management services link individuals using the service to service agencies and support systems responsible for providing the necessary direct service activities and coordinate and monitor those services.
b. Performance indicators.
(1) Staff clearly define the need for case management and document it annually.
(2) At a minimum, the team is composed of the individual using the service, the case manager, and providers or natural supports relevant to the individual's service needs. The team may also include family members, at the discretion of the individual using the service.
(3) The team works with the individual using the service to establish the service plan that guides and coordinates the delivery of the services.
(4) The case manager advocates for the individual using the service.
(5) The case manager coordinates and monitors the services provided to the individual using the service.
(6) Documentation of contacts includes the date, the name of the individual using the service, the name of the case manager, and the place of service.
(7) The case manager holds individual face-to-face meetings at least quarterly with the individual using the service.
(8) Case managers do not provide direct services. Individuals using the service are linked to appropriate resources, which provide necessary direct services and natural supports.
(9) Individuals using the service participate in developing an individualized crisis intervention plan that includes natural supports and self-help methods.
(10) Documentation shows that individuals using the service are informed about their choice of providers as provided in the county management plan.
(11) Within an accredited case management program, the average caseload is no more than 45 individuals per each full-time case manager. The average caseload of children with serious emotional disturbance is no more than 15 children per full-time case manager.
(12) The case manager communicates with the team and then documents in the individual's file a quarterly review of the individual's progress toward achieving the goals

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five 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:**
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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.

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.

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

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).

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

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

Unit of service: 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 04, 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.

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
Agency	IBICA (International Brain Injury Clubhouse Alliance)
Agency	CQL

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 Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

79.39(22)
Providers of prevocational services must be accredited by one of the following:
a. The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.

Other Standard *(specify):*

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.
(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:

The Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five 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:

IBICA (International Brain Injury Clubhouse Alliance)

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.
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.
(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:

Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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

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.
(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 Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every Five 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:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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.

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

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

The following limitations apply:
a.Services provided outside the members home shall not be reimbursable if the living unit where the respite is provided is reserved for another person on a temporary leave of absence.
b.Staff-to-consumer ratios shall be appropriate to the individual needs of the member as determined by the members interdisciplinary team.
c. A unit of service is 15 minutes. There is an upper limit set for rates based on provider type that is subject to change on a yearly basis.
d. The service shall be identified in the members individual comprehensive plan.
f. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS BI waiver supported community living services, Medicaid nursing, or Medicaid BI home health aide services.
g. 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 camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
h. “Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.
“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one
“Specialized respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.”
i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
j. 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.

Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care provided outside of the member's home. This may include Intermediate Care Facilities for persons with Intellectual Disabilities (ICF/ID, residential care facilities for persons with Intellectual Disabilities(RCF/ID), licensed foster care homes, Camps accredited by the American Camping Association, and hotels and motels. Hotels and motels are used based on individual need, the FFP is considered to be included within the rate paid to the respite provider.

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	Facility - Nursing Facility
Agency	Camps
Agency	Facility - Residential Care Facility
Agency	Assisted Living Programs
Agency	Agency
Agency	Group Living Foster Care Facility
Agency	Home Care Agency
Agency	Child Care Facility
Agency	Adult Day Care
Agency	Facility - Hospital
Agency	Facility ICF/ID

Provider Category	Provider Type Title
Agency	Home Health

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Facility - Nursing Facility

Provider Qualifications

License *(specify):*

Liscensed by the Department of Inspections and Appeals 481 IAC Chpaters 58 and 61.

Certificate *(specify):*

Other Standard *(specify):*

Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.
(1) Procedures for establishing health care facilities as Medicaid facilities. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "State Operations Manual."
a. The facility shall obtain the applicable license from the department of inspections and appeals and must be recommended for certification by the department of inspections and appeals.
b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.
c. The Iowa Medicaid enterprise provider services unit shall transmit an application form and a copy of the nursing facility provider manual to the facility.
d. The facility shall complete its portion of the application form and submit it to the Iowa Medicaid enterprise provider services unit.
e. The Iowa Medicaid enterprise provider services unit shall review the application form
and verify with the department of inspections and appeals that the facility is licensed and has been recommended for certification.
f. Prior to requesting enrollment, the facility shall contact the department of inspections and appeals to schedule a survey. The department of inspections and appeals shall schedule and complete a survey of the facility.
g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.
h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.
i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.
j. When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.
(2) Medicaid provider agreements. The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification
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.
(3) Policies shall be developed for:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
c. 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.
d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the

interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services

Frequency of Verification:

Every five 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 certified by the American Camping Association. 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 Health and Human Services, Iowa Medicaid, Provider services

Frequency of Verification:

Every five 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:

Facility - Residential Care Facility

Provider Qualifications

License *(specify):*

RCF liscensed by the Department of Inspections and Appeals under 481 IAC Chapter 57

Certificate *(specify):*

Other Standard *(specify):*

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:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
c. 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.
d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five 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:

Assisted Living Programs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Department of Inspections and Appeals UInder 481 IAC Chapter 67
Initial certification process for a nonaccredited program.
(1) Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation review approval, the department shall determine whether or not the proposed program meets applicable requirements.
(2) If, based upon the review of the complete application including all required supporting documents, the department determines the proposed program meets the requirements for certification; a provisional certification shall be issued to the program to begin operation and accept tenants.
(3) Within 180 calendar days following issuance of provisional certification, the department shall conduct a monitoring to determine the program's compliance with applicable requirements.
(4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B,231C,231D) shall be followed.
(5) The department shall make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.
(6) The department shall notify the program of a final certification decision within 10 working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.
(7) If the decision is to continue certification, the department shall issue a full two-year certification effective from the date of the original provisional certification.

Initial certification process for an accredited program.
(1) Within 20 working days of receiving all finalized documentation, including state fire marshal approval, the department shall determine and notify the accredited program whether or not the accredited program meets applicable requirements and whether or not certification will be issued.
(2) If the decision is to certify, a certification shall be issued for the term of the accreditation not to exceed three years, unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.
(3) If the decision is to deny certification, the department shall provide the applicant an opportunity for hearing in accordance with rule 481—67.13(17A,231B,231C,231D).
(4) Unless conditionally issued, suspended or revoked, certification for a program shall expire at the end of the time period specified on the certificate

Other Standard *(specify):*

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.
(3) Policies shall be developed for:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
c. 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.
d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Health and Human Services, the Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five 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:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Agencies certified by the department to provide respite in a member's home that meet the organizational standards set forth in 441 IAC 77.39(1), 77.39(3)through 77.39(7)

Other Standard *(specify):*

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:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
c. 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.
d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditationin these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five 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:

Group Living Foster Care Facility

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
c. 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.
d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five 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 Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Home care agencies that meet the Home Care requirements set forth in IAC 641-80.5(135), 641- 80.6 (1350 and 641-80.7 (135) or certified by Medicare as a Home Health agency

Other Standard *(specify):*

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:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
c. 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.
d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five 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:

Child Care Facility

Provider Qualifications

License *(specify):*

Child Care Facilities that are defined as child care centers, preschools, or child development homes registered pursuant to 441 IAC chapter 110.

Certificate *(specify):*

Other Standard *(specify):*

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:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
c. 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.
d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services

Frequency of Verification:

Every five 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:

Adult Day Care

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Department of Inspections and Appeals as being in compliance with the standards for adult day services programs adopted by the departmentof elder affairs at 321 - Chapter 24.

Other Standard *(specify):*

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:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
c. 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.
d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five 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:

Facility - Hospital

Provider Qualifications

License *(specify):*

Liscensed by the Department of Inspections and Appeals under 481 Chapter 51

Certificate *(specify):*

Other Standard *(specify):*

Enrolled as an Iowa Medicaid provider.
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:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
c. 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.
d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:

Facility ICF/ID

Provider Qualifications

License *(specify):*

Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) liscensed by the Department of Inspections and Appeals 481 IAC Chapters 63 and 64.

Certificate *(specify):*

Other Standard *(specify):*

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:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
c. 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.
d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five 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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

441 IAC 77.9 (249A) Home Health Agency certified by Medicare

Other Standard *(specify):*

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:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
c. 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.
d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Health and Human Services, the Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
03 Supported Employment	03022 ongoing supported employment, group
Category 4:	**Sub-Category 4:**
03 Supported Employment	03030 career planning

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

Scope. 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 under subparagraph 78.27(10)"a"(4), 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.
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 hour 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.

Scope. 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.

Providers delivering this service via the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given when client needs include: accessibility, translation, or limited auditory or visual capacities are present;
•Have a contingency plan for provision of services if technology fails;
•Professionals do not practice outside of their respective scope; and
•Assessment of clients and caregivers that identifies a client's ability to participate in and outlines any accommodations needed while using Telehealth.
These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

In-person contact is not required as a prerequisite for payment.

Additional information for for telehealth can be found in Main B. Optional

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

A unit of service for Individual SE 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 or hourly for individuals requiring 25 or more hours of service per month. 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) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.
(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed $3,029.00 per month. 441 -1.8(17A, 217) provides for waiver of administrative rules in exceptional circumstances.
(3) Individual supported employment is limited to 240 units per calendar year.
(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

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	CAFC
Agency	CQL
Agency	CARF
Agency	IBICA International Brain Injury Clubhouse Alliance
Agency	JCAHO
Agency	ICCD

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

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:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every Five 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

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:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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

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:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every Five 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:

IBICA International Brain Injury Clubhouse Alliance

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An agency that is accredited by International Brain Injury Clubhouse Alliance

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:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:

JCAHO

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:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every Five 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:

ICCD

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:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every Five 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:

Specialized Medical Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized Medical Equipment shall include medically necessary items for personal use by the member with a brain injury which provide for the health and safety of the member which are not ordinarily covered by Medicaid, and are not funded by educational or vocational rehabilitation programs, and are not provided on a voluntary means. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan including EPSDT, but consistent with waiver objectives of avoiding institutionalization and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture design and installation. This includes but is not limited to : electronic aids and organizaers, electronic mediation dispensing devices, communication devices, bath aids, and noncovered environmental control units. This includes repair and maintenace of items purchased through the waiver in addition to initial purchase cost.

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

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

Members may receive specialized medical equipment once per month until a maximum yearly usage of $6,366.64 per
year has been reached. The yearly usage dollar amount is subject to change on an annual basis. The upper rate limits are published in 441 IAC Chapter 79.
A unit of service is one occurrence. The services under the Brain Injury Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

The maximum dollar limit allowed for specialized medical equipment is based on historical expenditure/utilization patterns. The department would adjust the limit based on appropriation from the Iowa legislature increased HCBS waiver rates.
Members enrolled in the BI waiver have access to Iowa's Medicaid Exception to Policy option. ETPs can be requested to Iowa Administrative Code (IAC) rules, but cannot be requested for Federal requirements or state law. Members needing specialized medical equipment whose cost exceeds the limit allowed in administrative rule may request an ETP to exceed the limit. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding ETP requests are approved by the Department of Health and Human Services director.

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	Medical Equipment and Supply dealers
Agency	Retail and Wholesale businesses

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Medical Equipment and Supply dealers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

441—77.10(249A) All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other
states are eligible to participate in the program.

Other Standard *(specify):*

Enrolled as a provider in the Medicaid program

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this 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:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Upon enrollment and every five years

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Retail and Wholesale businesses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled a providers in the Medicaid program. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Upon enrollment and every five 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 Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The Financial Management Service (FMS) is necessary for all members choosing the self-direction option, and is available only to those who self direct. The FMS is enrolled 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. For those members who self-direct, the FMS will:

· Establish and manage members and directly hired workers documents and files
· Manage and monitor timesheets and invoices to assure that they match the written budget
· Provide monthly and quarterly status reports for the Department and for the member that include a summary of expenditures paid and amounts of budgets that are unused.
· Assist members in understanding their fiscal/payroll related responsibilities
· Assist members in completing required federal, state and local tax and insurance forms
· Assist members in conducting criminal background checks on potential employees, if requested
· Assist members in verifying service workers citizenship or alien status
· Prepares and disburses payroll if a program member hires workers. Key employer-related tasks include:
· Verifying that service workers' hourly wages are in compliance with federal and state Department of Labor rules;
· Collecting and processing services workers' timesheets;
· Withholding, filing and paying federal, state and local income, Medicare and Social Security (FICA), federal (FUTA) and state (SUTA) unemployment and disability insurance (as applicable) taxes'
· Computing and processing other benefits, as applicable;
· Preparing and issuing service workers' payroll checks;
· Refunding over collected FICA, when appropriate (Fiscal/Employer Agent)
· Refunding over collected FUTA, when appropriate (Fiscal/Employer Agent)
· Processing all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws, and
· Prepare and disburse IRS Forms W-2 and W-3 annually.
· Process and pay invoices for approved goods and services included in program members' budgets;
· Assists in implementing the state's quality management strategy related to FMS
· Establish an accessible customer service system and communication path for the member and the Individual Support Broker
· Provide monthly statements of Individual Budget account balances to both the Individual Support Broker and the member
· Provide real time Individual Budget account balances, at a minimum during normal business hours (9-5, Monday Friday)
· Ability to interface with the tracking system chosen by the Iowa Department of Heatlh and Human Services

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

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

A member who elects the consumer choices option may purchase the following services and supports, which shall be provided in the member's home or at an integrated community setting:
(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community.
(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration.
(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the member's service plan. The item or service shall decrease the member's need for other Medicaid services, promote the member's inclusion in the community, or increase the member's safety in the community.

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 Management Service

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Service

Provider Category:

Agency

Provider Type:

Financial Management Service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Financial Management Service must meet the criteria under 441 IAC Chapter 77.

Financial Institution that meets the following qualifications.
a. 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).

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ◉ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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.

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

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 26 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.

A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan. The Case Manger oversees the services authorized to develop the monthly CCO budget. Independent Support Broker must 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. The Case Manager, the Financial Management Service and the department may review this documentation at any time.

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.
a. The broker must be at least 18 years of age.
b. 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.
c. The broker shall not provide any other paid service to the member.
d. The broker shall not work for an individual or entity that is providing services to the member.
e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
f. The broker must complete independent support brokerage training approved by the department.
g. The broker will not work for an individual or entity that is providing services to the member.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

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 Health and Human Services Iowa Medicaid. The Independent Support Broker will be responsible for attending one support broker training a year held at the HCBS regional meetings.

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:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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.

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

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 followiong 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
Individual	Business

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

Provider Qualifications

License *(specify):*

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. The type of license needed will be dependent on the type of good or service being purchased through CCO. It is the responsibility of the member to assure that any good or service being purchased through CCO that requires licensure has the needed licensure prior to the purchase of the good or service.

Certificate *(specify):*

Other Standard *(specify):*

All persons providing these services must be at least 18 years of age. All persons must be able to demonstrate to the member the ability to perform the task or tasks hire to perform. All persons hired must have the availability to successfully communicate with the member. Individuals and businesses providing services and supports shall have all the necessary licenses required by federal state and local laws and regulations

The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:
(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.

Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, the independent support broker and the financial management service

Frequency of Verification:

Every five years. The member retains the employer authority

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:

Business

Provider Qualifications

License *(specify):*

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. The type of license needed will be dependent on the type of good or service being purchased through CCO. It is the responsibility of the member to assure that any good or service being purchased through CCO that requires licensure has the needed licensure prior to the purchase of the good or service.

Certificate *(specify):*

Other Standard *(specify):*

All persons providing these services must be at least 18 years of age. All persons must be able to demonstrate to the member the ability to perform the task or tasks hire to perform. All persons hired must have the availability to successfully communicate with the member. Individuals and businesses providing services and supports shall have all the necessary licenses required by federal state and local laws and regulations

The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:
(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.
j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual, Individual Support Broker, Financial Management Service

Frequency of Verification:

Every five 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:

Other Supports for Participant Direction

Alternate Service Title (if any):

Self Directed Community Support and Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual

Category 2:	**Sub-Category 2:**
13 Participant Training	13010 participant training
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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:

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

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.

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

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

Limits
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 BI waiver allows for the following eight BI waiver services to be converted to create a CCO budget:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Prevocational services.
4. Basic individual respite care.
5. Specialized medical equipment.
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):*

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. The type of license needed will be dependent on the type of good or service being purchased through CCO. It is the responsibility of the member to assure that any good or service being purchased through CCO that requires licensure has the needed licensure prior to the purchase of the good or service.

Certificate *(specify):*

Other Standard *(specify):*

All persons providing these services must be at least 18 years of age. All persons must be able to demonstrate to the member the ability to successfully communicate with the member. Individuals and businesses providing services and supports shall have all the necessary licenses required by federal, state and local laws and regulations

The member shall have the authority to be the common-law employer
of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:
(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.
Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities

Verification of Provider Qualifications

Entity Responsible for Verification:

The individual, Individual Support Broker and the Financial Management Service

Frequency of Verification:

Every five years

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):*

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. The type of license needed will be dependent on the type of good or service being purchased through CCO. It is the responsibility of the member to assure that any good or service being purchased through CCO that requires licensure has the needed licensure prior to the purchase of the good or service.

Certificate *(specify):*

Other Standard *(specify):*

All persons providing these services must be at least 18 years of age. All persons must be able to demonstrate to the member the ability to successfully communicate with the member. Individuals and businesses providing services and supports shall have all the necessary licenses required by federal, state and local laws and regulations

The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform
the following functions:
(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.

Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, the Independent Support Broker and the Financial Management Service.

Frequency of Verification:

Every five years. The member retains the employer authority

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:**
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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.

Health-related services that are provided may include skilled or nursing care and medication administration to the extent that the individual holds the appropriate certification and/or licensure and as permitted by State law. These services are only available for those that self-direct. 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 IoWANS system. The case manager and interdisciplinary team determine which service is necessary and authorize services 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.

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

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. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan. The Case Manger oversees the services authorized to develop the monthly CCO budget as well as traditional services accessed.

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.

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 Personal Care

Provider Category:

Agency

Provider Type:

Business

Provider Qualifications

License *(specify):*

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. The type of license needed will be dependent on the type of good or service being purchased through CCO. It is the responsibility of the member to assure that any good or service being purchased through CCO that requires licensure has the needed licensure prior to the purchase of the good or service.

Certificate *(specify):*

Other Standard *(specify):*

All persons providing these services must be at least 16 years of age. All persons must be able to demonstrate to the consumer the ability to successfully communicate with the consumer. Individuals and businesses providing services shall have all the necessary licenses required by federal, state and local laws and regulations. The consumer and the independent support broker are responsible for determining provider qualifications for the individual employees identified on the individual budge.

A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11).

The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:
(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.

Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities

Verification of Provider Qualifications

Entity Responsible for Verification:

The individual, Individual Support Broker and the Financial Management Service

Frequency of Verification:

Every Five Years

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):*

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. The type of license needed will be dependent on the type of good or service being purchased through CCO. It is the responsibility of the member to assure that any good or service being purchased through CCO that requires licensure has the needed licensure prior to the purchase of the good or service.

Certificate *(specify):*

Other Standard *(specify):*

All persons providing these services must be at least 16 years of age. All persons must be able to demonstrate to the consumer the ability to successfully communicate with the consumer. Individuals and businesses providing services shall have all the necessary licenses required by federal, state and local laws and regulations. The consumer and the independent support broker are responsible for determining provider qualifications for the individual employees identified on the individual budget. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11).

The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:
(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.

Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities

Verification of Provider Qualifications

Entity Responsible for Verification:

The member and the Independent Support Broker and the Financial Management Service.

Frequency of Verification:

Every five years, the member retains the employer authority

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:

Behavioral Programming

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Behavioral Programming consists of individually designed strategies to increase the member's appropriate behaviors and decrease the member's maladaptive behaviors, which have interfered with the members ability to remain in the community. Behavioral programming consists of:
1. A complete assessment of both appropriate and maladaptive behaviors
2. Development of a structured behavioral intervention plan which should be identified in the Individual Treatment Plan.
3. Implementation of the behavioral intervention plan.
4. On-going training and supervision to caregivers and behavioral aides.
5. Periodic reassessment of the plan, but no less than quarterly.

Types of appropriate behavioral programming include but are not limited to : clinical redirection, token economies, reinformcement, extinction, modeling and over-learning.
Token economies reinforce desired behavior with a tangible reinforcement of the person’s preference. Clinical redirection includes verbal redirection or talking to the person to redirect their attention away for the targeted behavior or physical redirection by leading or guiding the person to a different environment, reinforcement may be verbal praise, a tangible object or preferred activity of the member. Extinction occurs when reinforcement of a previously reinforced behavior is discontinued. Modeling occurs when the person learns from watching someone else perform the desired behavior. Over Learning occurs when the person continues to practice newly acquired skills past the level of skill mastery.
The behavioral intervention plan goal must be identified in the member’s comprehensive service plan or treatment plan.
The behavioral programs developed must be developed using evidenced based practices and may not include any experimental approaches to behavioral support.
Behavioral programming may occur in the member's home or community.

Providers delivering this service via the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given when client needs include: accessibility, translation, or limited auditory or visual capacities are present;
•Have a contingency plan for provision of services if technology fails;
•Professionals do not practice outside of their respective scope; and
•Assessment of clients and caregivers that identifies a client's ability to participate in and outlines any accommodations needed while using Telehealth.

“Telehealth” means the delivery of services through the use of real-time interactive audio and video, or other real-time interactive electronic media, regardless of where the health care professional and the covered person are each located. “Telehealth” does not include the delivery of health care services delivered solely through an audio-only telephone, electronic mail message, or facsimile transmission.

The use of telehealth is not meant to replace the in-person supports for those individuals who require hands on or physical assistance during the service delivery.

The member’s case manager or community-based case manager is responsible for ensuring that the member has been provided the appropriate training on the use of the telehealth technology within the home including how to disable and shut off the technology.

The use of telehealth can assist individuals to live more independently and support a safe transition to independent living while enhancing their self-advocacy skills and increase opportunities for participating in the community.

Telehealth is an available service delivery modality when the member chooses to receive their services via telehealth and the service modality is clinically appropriate to the member's assessed needs.

The state works closely with the agency providers to develop and provide training and other resources on the delivery of HCBS. The state will continue to support individuals receiving HCBS through the established service monitoring activities of the Care Coordinators, Case Managers, and Community-Based Case Managers, the quality oversight activities of the HCBS QIO and providing technical assistance, information and additional resources as the need is identified.

Services delivered via telehealth will be delivered in a setting/location that protects the waiver participants privacy and therefore not permitted to be delivered in settings such as bathrooms.

In-person contact is not required as a prerequisite for payment.

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

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

A unit of service is 15 minutes. There is an upper rate limit for this service which is subject to change on a yearly basis.

Members enrolled in the waiver have access to Iowa's Medicaid Exception to Policy (ETP) option. ETPs can be requested to Iowa Administrative Code (IAC) rules but cannot be requested for Federal requirements or state law. Members needing additional services in order to ensure health, safety, or other issues can request ETPs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding ETP requests are approved by the Department of Health and Human Services director.

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	Hospice Provider
Agency	Community Mental Health Center
Agency	Home Health Agency
Agency	Brain Injury Waiver Providers
Agency	Mental Health Service Provider
Agency	Agencies which are accredited by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency

Provider Type:

Hospice Provider

Provider Qualifications

License *(specify):*

Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481Chapter 53

Certificate *(specify):*

Agencies which are certified to meet the standards under the Medicare program for hospice programs.

Other Standard *(specify):*

Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury.
In addition, they must meet the following requirements.
a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441- 83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency

Provider Type:

Community Mental Health Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441IAC Chapter 24

Other Standard *(specify):*

Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall: Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio. Reflect how program continuity will be provided. Reflect an interdisciplinary team of professionals and paraprofessionals .Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor’s degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; post discharge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient’s case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider’s program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient’s progress.

Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury.
In addition, they must meet the following requirements.
a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441- 83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health Agency providers certified by Medicare shall be considered to have met these standards.

Other Standard *(specify):*

Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury.
In addition, they must meet the following requirements.
a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441- 83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency

Provider Type:

Brain Injury Waiver Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers enrolled to deliver HCBS BI Waiver services in accordance with 441 IAC Chapter 77.39

Other Standard *(specify):*

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist
(CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.
Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.
In addition, supported community living, providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Organizational standards (Outcome 1). Organizational outcome-based standards for
HCBS BI providers are as follows:
a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.
b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.
c. The organization establishes and maintains fiscal accountability.
d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.
e. The organization provides needed training and supports to its staff. This training includes at a minimum:
(1) Consumer rights.
(2) Confidentiality.
(3) Provision of consumer medication.
(4) Identification and reporting of child and dependent adult abuse.
(5) Individual consumer support needs.
f. The organization has a systematic, organization wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:
(1) Measures and assesses organizational activities and services annually.
(2) Gathers information from consumers, family members, and staff.
(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).
(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.
(5) Identifies areas in need of improvement.
(6) Develops a plan to address the areas in need of improvement.
(7) Implements the plan and documents the results.
g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.
h. The provider shall have written policies and procedures and a staff training program for the

identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.
i. The governing body has an active role in the administration of the agency.
j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury.
In addition, they must meet the following requirements.
a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441- 83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency

Provider Type:

Mental Health Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441 IAC Chapter 24, Divisions I and IV.

Mental health service provider" means an organization whose services are established to specifically address mental health services to individuals or the administration of facilities in which these services are provided. Organizations included are:
1. Those contracting with a county board of supervisors to provide mental health services in lieu of that county's affiliation with a community mental health center (Iowa Code chapter 230A).
2. Those that may contract with a county board of supervisors for special services to the general public or special segments of the general public and that are not accredited by any other accrediting body. These standards do not apply to individual practitioners or partnerships of practitioners covered under Iowa's professional licensure laws.

Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury.
In addition, they must meet the following requirements.
a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441- 83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency

Provider Type:

Agencies which are accredited by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Accreditation by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Consumer-directed attendant care 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. Consumer-directed attendant care may occur in the member's home or community.
The service activities may include helping the member with any of the following nonskilled 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. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.
(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.
(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.
(6) Housekeeping services which are essential to the members health care at home.
(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.
(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 consumer-directed attendant care services.
(10) Cognitive assistance with tasks such as handling money and scheduling.
(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.
(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

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

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

A unit of services is 15 minutes. Services are billed in whole units. There are upper rate limits which are subject to change on a yearly basis.

The first line of prevention of duplicative billing for similar types of services, such as home health aide, 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, they are responsible to assure that the services are being delivered as ordered. The IoWANS 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.

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	Community Action Agency
Agency	Adult Day Care provider
Agency	Assisted Living provider
Individual	Individual
Agency	Community Business
Agency	Home Health Agency
Agency	Chore provider
Agency	Supported Community Living Provider
Agency	Home Care Agency

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.
"Community action agency" means a public agency or a private nonprofit agency which is authorized under its charter or bylaws to receive funds to administer community action programs and is designated by the governor to receive and administer the funds Establishment of community action agencies.
The division shall recognize and assist in the designation of certain community action agencies to assist in the delivery of community action programs. These programs shall include but not be limited to outreach, community services block grant, low-income energy assistance, and weatherization programs. If a community action agency is in effect and currently serving an area, that community action agency shall become the designated community action agency for that area. If any geographic area of the state ceases to be served by a designated community action agency, the division may solicit applications and assist the governor in designating a community action agency for that area in accordance with current community services block grant requirements.

Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST).

Personnel delivering CDAC services must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) 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.
(4) All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. All CDAC agency employees delivering CDAC must complete criminal and adult/child abuse background checks prior to service provision. 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:

Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:

Adult Day Care provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Adult day care providers that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321Chapter 24

Other Standard *(specify):*

Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST).

Personnel delivering CDAC services must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) 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.
(4) All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. All CDAC agency employees delivering CDAC must complete criminal and adult/child abuse background checks prior to service provision. 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:

Department of Human Service 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: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Agency

Provider Type:

Assisted Living provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Assisted living programs certified by the department of inspections and appeals 481 IAC Chapter 67
Initial certification process for a nonaccredited program.
(1) Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation review approval, the department shall determine whether or not the proposed program meets applicable requirements.
(2) If, based upon the review of the complete application including all required supporting documents, the department determines the proposed program meets the requirements for certification; a provisional certification shall be issued to the program to begin operation and accept tenants.
(3) Within 180 calendar days following issuance of provisional certification, the department shall conduct a monitoring to determine the program's compliance with applicable requirements.
(4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B,231C,231D) shall be followed.
(5) The department shall make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.
(6) The department shall notify the program of a final certification decision within 10 working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.
(7) If the decision is to continue certification, the department shall issue a full two-year certification effective from the date of the original provisional certification.

Initial certification process for an accredited program.
(1) Within 20 working days of receiving all finalized documentation, including state fire marshal approval, the department shall determine and notify the accredited program whether or not the accredited program meets applicable requirements and whether or not certification will be issued.
(2) If the decision is to certify, a certification shall be issued for the term of the accreditation not to exceed three years, unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.
(3) If the decision is to deny certification, the department shall provide the applicant an opportunity for hearing in accordance with rule 481—67.13(17A,231B, 231C, 231D).
(4) Unless conditionally issued, suspended or revoked, certification for a program shall expire at the end of the time period specified on the certificate

Other Standard *(specify):*

Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST).

Personnel delivering CDAC services must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) 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.
(4) All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. All CDAC agency employees delivering CDAC must complete criminal and adult/child abuse background checks prior to service provision. 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:

Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST).

Personnel delivering CDAC services must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) 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.
(4) All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. All CDAC individual providers delivering CDAC must complete criminal and adult/child abuse background checks prior to service provision. 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.

All personnel providing self-directed CDAC-unskilled through CCO 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Huan Serices, Iowa Medicaid, Provider Services Unit
For CCO employees, the Financial Management Service.

Frequency of Verification:

Every five 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 Business

Provider Qualifications

License *(specify):*

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

Certificate *(specify):*

Other Standard *(specify):*

Community businesses that are engaged in the provision of personal care services and that submit verification of current liability and workers' compensation coverage.

Providers must be:
1. At least 18 years of age.
2. Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
3. 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.

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

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or childcare for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the case manager and CBCMs shall oversee service provision.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five 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):*

441—77.9(249A) Home health agencies. Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6)

Other Standard *(specify):*

Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST).

Personnel delivering CDAC services must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) 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.
(4) All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. All CDAC agency employees delivering CDAC must complete criminal and adult/child abuse background checks prior to service provision. 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 Health and Human Services, Iowa Medicaid

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:

Chore provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

441 IAC 77.33(7)Chore providers
a. Home health agencies certified under Medicare.
b. Community action agencies as designated in Iowa Code section 216A.93.
c. Agencies authorized to provide similarservicesthrough a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
e. Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.
f. Community businesses that are engaged in the provision of chore services and that:
(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and
(2) Submit verification of current liability and workers' compensation coverage

Other Standard *(specify):*

Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST).

Personnel delivering CDAC services must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) 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.
(4) All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. All CDAC agency employees delivering CDAC must complete criminal and adult/child abuse background checks prior to service provision. 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:

Department of Health and Human Services Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five 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 Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers certified under an HCBS waiver for supported community living. Supported Community Living Provider requirements are listed in 441 IAC Chapter 77.

Other Standard *(specify):*

Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST).

Personnel delivering CDAC services must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) 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.
(4) All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. All CDAC agency employees delivering CDAC must complete criminal and adult/child abuse background checks prior to service provision. 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:

Department of Health and Human Services, Iowa Medicaid

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 Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Eligible Home care agencies are those that meet the conditions set forth in Iowa Administrative Code 441--77.33(4).
a. Certified as a home health agency under Medicare, or
b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

Other Standard *(specify):*

Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST).

Personnel delivering CDAC services must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) 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.
(4) All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. All CDAC agency employees delivering CDAC must complete criminal and adult/child abuse background checks prior to service provision. 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:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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 - Skilled

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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, CBCM, or integrated health home care coordinator 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, remotivation, 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) Postsurgical 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.

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

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

A unit of service is 15 minutes provided by an individual or an agency.
Each service shall be billed in whole units.

CDAC may be provided to a recipient of in-home health related care services, but not at the same time.

There is an upper limit for both agency and individual providers. These are subject to change on a yearly basis.

The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

These services may not duplicate services provided under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Members enrolled in the waiver have access to Iowa's Medicaid Exception to Policy option. ETPs can be requested to Iowa Administrative Code (IAC) rules but cannot be requested for Federal requirements or state law. Members needing additional services in order to ensure health, safety, or other issues can request ETPs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding ETP requests are approved by the Department of Health and Human Services director.

The services under the 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 provider
Agency	Assisted Living Program
Agency	Chore Provider
Agency	Home Health Agency
Agency	Community Action Agency
Agency	Community Business
Agency	Home Care Agency
Individual	Individual
Agency	Adult Day Service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Supported Community Living provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers certified under an HCBS waiver for supported community living listed in 441 IAC Chapter 77.

Other Standard *(specify):*

oProviders initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST).

Personnel delivering CDAC services must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Assisted Living Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Assisted living programs certified by the department of inspections and appeals 481 IAC Chapter 67

Other Standard *(specify):*

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.
Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.

Initial certification process for a nonaccredited program.
(1) Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation review approval, the department shall determine whether or not the proposed program meets applicable requirements.
(2) If, based upon the review of the complete application including all required supporting documents, the department determines the proposed program meets the requirements for certification; a provisional certification shall be issued to the program to begin operation and accept tenants.
(3) Within 180 calendar days following issuance of provisional certification, the department shall conduct a monitoring to determine the program's compliance with applicable requirements.
(4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B,231C,231D) shall be followed.
(5) The department shall make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.
(6) The department shall notify the program of a final certification decision within 10 working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.
(7) If the decision is to continue certification, the department shall issue a full two-year certification effective from the date of the original provisional certification.

Initial certification process for an accredited program.
(1) Within 20 working days of receiving all finalized documentation, including state fire marshal approval, the department shall determine and notify the accredited program whether or not the accredited program meets applicable requirements and whether or not certification will be issued.
(2) If the decision is to certify, a certification shall be issued for the term of the accreditation not to exceed three years, unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.
(3) If the decision is to deny certification, the department shall provide the applicant an opportunity for hearing in accordance with rule 481—67.13(17A,231B,231C,231D).
(4) Unless conditionally issued, suspended or revoked, certification for a program shall expire at the end of the time period specified on the certificate.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Chore Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.Providers must be:
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.

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department’s brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.
Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Home Care Agency requriements are listed in 441 IAC Chpater 77.
Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

Other Standard *(specify):*

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.
Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

o Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST).

Personnel delivering CDAC services must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) 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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Community Business

Provider Qualifications

License *(specify):*

Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

Certificate *(specify):*

Other Standard *(specify):*

Community businesses that are engaged in the provision of personal care services and that submit verification of current liability and workers' compensation coverage.

Providers must be:
1. At least 18 years of age.
2. Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
3. 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.

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

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or childcare for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the case manager and CBCMs shall oversee service provision.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(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 department of public health rules 641Iowa Administrative Code 80.5(135), 80.6(135), and 80.7(135).

Other Standard *(specify):*

Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST).

Personnel delivering CDAC services must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

CDAC Provider Qualifications are listed in 441 IAC Chapter 77

Other Standard *(specify):*

Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST).

Personnel delivering CDAC services must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) 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.
(4) All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. All CDAC individual providers delivering CDAC must complete criminal and adult/child abuse background checks prior to service provision. 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.

All personnel providing self-directed CDAC-unskilled through CCO 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit
For CCO employees, the Financial Management Service.

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Adult Day Service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The Adult Day Care Provider standards are contained in the Department of Inspections and Appeals adminsitrative rules at 481 Iowa Adminsitrative Code Chapters 67 and 79.

Other Standard *(specify):*

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.
Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care providers must be at least 18 years of age.

Initial certification process for a nonaccredited program.
(1) Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation review approval, the department of inspections and appeals (DIA) shall determine whether the proposed program meets applicable requirements.
(2) If, based upon the review of the complete application, including all required supporting documents, the department determines the proposed program meets the requirements for certification, a provisional certification shall be issued to the program to begin operation and accept participants.
(3) Within 180 calendar days following issuance of provisional certification, the department shall conduct a monitoring to determine the program's compliance with applicable requirements.
(4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B, 231C,231D) shall be followed.
(5) The department shall make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.
(6) The department of inspections and appeals (DIA)shall notify the program of a final certification decision within 10 working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.

70.5(7) If the decision is to continue certification, the department shall issue a full two-year certification effective from the date of the original provisional certification.

Certification or recertification of an accredited program—application process.
70.9(1) An applicant for certification or recertification of a program accredited by a recognized accrediting entity shall:
a. Submit a completed application packet obtained from the department.
Application materials may be obtained from the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do; by mail from the Department of Inspections and Appeals, Adult Services Bureau, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083; or by telephone at (515)281-6325.
b. Submit a copy of the current accreditation outcome from the recognized accrediting entity.
c. Apply for certification or recertification within 90 calendar days following verification of compliance with life safety requirements pursuant to this chapter.
d. Maintain compliance with life safety requirements pursuant to this chapter.
e. Submit the appropriate fees as set forth in Iowa Code section 231D.4.
(2) The department shall not consider an application until it is complete and includes all supporting documentation and the appropriate fees

Recognized accrediting entity.

(1) The department designates CARF as a recognized accrediting entity for programs.
(2) To apply for designation by the department of inspections and appeals (DIA) as a recognized accrediting entity for programs, an accrediting entity shall submit a letter of request, and its standards shall, at minimum, meet the applicable requirements for programs.
(3) The designation shall remain in effect for as long as the accreditation standards continue to meet, at minimum, the applicable requirements for programs.
(4) An accrediting entity shall provide annually to the department, at no cost, a current edition of the applicable standards manual and survey preparation guide, and training thereon, within 120 working days after the publications are released.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:

Enabling Technology for Remote Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

"Enabling technology" means the technology that makes the on demand remote supervision and support possible and includes a device, product system, or engineered solution whether acquired commercially, modified, or customized that addresses an individual's needs and outcomes identified in his or her individual service plan. The service is for the direct benefit of the individual in maintaining or improving independence and functional capabilities. Remote support and monitoring will assist the individual to fully integrate into the community, participate in community activities, and avoid isolation.

Enabling technology may cover evaluation of the need for enabling technology and, if appropriate, subsequent selection of a device needed to improve a participant's ability to perform activities of daily living, control or access his/her environment or communicate. This service also includes equipment rental during a trial period, customization, and rental of equipment during periods of repair. Repair and maintenance of the technology is excluded.

Enabling technology (assessments only) remote support, is the following: Remote Support is the provision of Supported Community Living by a trained remote support professional who is in a remote location and is engaged with a person through enabling technology that utilizes live two-way communication in addition to or in place of on-site staffing. Remote support is not a service. It is an available delivery option through the Supported Community Living service to meet an individual's health, safety and other support needs as needed when it:

- Is chosen and preferred as a service delivery method by the person or their guardian (if applicable)
- Appropriately meets the individual's assessed needs.
- Is provided within the scope of the service being delivered.
- Is provided as specified in the individual's support plan.

Remote supports are delivered by awake; alert remote support professionals whose primary duties are to provide remote supports from the provider's secure remote supports location. To ensure safety and Health Insurance Portability and Accountability Act (HIPAA) compliance, this location should have appropriate, stable, and redundant connections. This should include, but is not limited to, backup generators or back battery, multiple internet service connections.

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

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

Unit of service is one job. There is an annual per member limitation for Enabling Technology of $4,000 per member per year.

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	Enabling Technology/Equipment providers that meet the Enabling Technology service standards
Individual	Enabling Technology/Equipment providers that meet the Enabling Technology service standards
Individual	Enabling Technology Assessment providers
Agency	Enabling Technology Assessment providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Enabling Technology for Remote Support

Provider Category:

Agency

Provider Type:

Enabling Technology/Equipment providers that meet the Enabling Technology service standards

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The support planning team will identify the person(s) or entity experienced in the area of Enabling Technology and its application for people with disabilities as qualified to provide and ensure that:
a) an evaluation of the participant's need for an assessment of potential for successful utilization of enabling devices occurs;
b) the appropriate and cost-effective device is selected from available options;
c) the appropriate device is procured;
d) training and technical assistance to the participant, caregiver and staff for the proper utilization of the device occurs; and
e) appropriate evaluation methods are developed to assure that the intended outcome(s) of the technology is achieved.

Enabling technology equipment services must provide a cost-effective, appropriate means of meeting the needs defined in the member's person-centered service plan.
All items shall meet applicable standards of manufacture, design and installation.

Providers delivering Enabling Technology needs must be one of the following professionals:
- Providers enrolled to deliver HCBS BI or ID waiver Supported Community Living
- Providers enrolled to deliver HCBS Habilitation Home-Based Habilitation
- Other qualified by training or experience to provide enabling technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Enabling Technology for Remote Support

Provider Category:

Individual

Provider Type:

Enabling Technology/Equipment providers that meet the Enabling Technology service standards

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The interdisciplinary team will identify the person(s) or entity experienced in the area of Enabling technology and its application for people with disabilities as qualified to provide and ensure that:
a) an evaluation of the participant's need for an assessment of potential for successful utilization of enabling devices occurs;
b) the appropriate and cost-effective device is selected from available options;
c) the appropriate device is procured;
d) training and technical assistance to the participant, caregiver and staff for the proper utilization of the device occurs; and
e) appropriate evaluation methods are developed to assure that the intended outcome(s) of the technology is achieved.
Enabling technology equipment services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's support plan.
All items shall meet applicable standards of manufacture, design and installation.

Providers delivering Enabling Technology needs must be one of the following professionals:
- Provider enrolled to deliver HCBS BI or ID waiver Supported Community Living
- Providers enrolled to deliver HCBS Habilitation Home-Based Habilitation
- Other qualified by training or experience to provide enabling technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Serivces, Iowa Medicaid

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Enabling Technology for Remote Support

Provider Category:

Individual

Provider Type:

Enabling Technology Assessment providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The support planning team will identify the person(s) or entity experienced in the area of enabling technology and its application for people with disabilities as qualified to provide and ensure that:
a) an evaluation of the participant's need for an assessment of potential for successful utilization of enabling devices occurs;
b) the appropriate and cost-effective device is selected from available options;
c) the appropriate device is procured;
d) training and technical assistance to the participant, caregiver and staff for the proper utilization of the device occurs; and
e) appropriate evaluation methods are developed to assure that the intended outcome(s) of the technology is achieved.

Providers evaluating enabling technology needs must be one of the following professionals:
- Certification through the Rehabilitation Engineering and Assistive Technology Society
- Certification through California State University Northridge's Assistive Technology Program
- Occupational therapists must currently be registered by the American Occupational Therapy
- Association as an occupational therapist
- Physical therapists must be a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent and licensed in Iowa.
- Speech-language pathologists must have a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association.
- Other professionals qualified by training and or experience to conduct technology assessments.

Additionally, enabling technology evaluation professionals must apply the standards in Iowa Code concerning criminal background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Enabling Technology for Remote Support

Provider Category:

Agency

Provider Type:

Enabling Technology Assessment providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The interdisciplinary team will identify the person(s) or entity experienced in the area of enabling technology and its application for people with disabilities as qualified to provide and ensure that:
a) an evaluation of the participant's need for an assessment of potential for successful utilization of enabling devices occurs;
b) the appropriate and cost-effective device is selected from available options;
c) the appropriate device is procured;
d) training and technical assistance to the participant, caregiver and staff for the proper utilization of the device occurs; and
e) appropriate evaluation methods are developed to assure that the intended outcome(s) of the technology is achieved.

Providers assessing Enabling Technology needs must be one of the following professionals:
- Certification through the Rehabilitation Engineering and Assistive Technology Society
- Certification through California State University Northridge's Assistive Technology Program
- Occupational therapists must currently be registered by the American Occupational Therapy Association as an occupational therapist.
- Physical therapists must be a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent and licensed in Iowa.
- Speech-language pathologists must have a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association.
- Other professionals qualified by training and or experience to conduct enabling technology assessments.

Additionally, Enabling Technology assessment professionals must apply the standards in Iowa code concerning criminal background checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Human Services, Iowa Medicaid

Frequency of Verification:

Every five 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:

Family Counseling and Training Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Family counseling and training services are face-to-face mental health services provided to the member and the family with whom the member lives (or who routinely provides care to the member) to increase the member's or family members' capabilities to maintain and care for the member in the community.
Family counseling and training may be provided by:
♦ Community mental health centers
♦ Hospices (licensed or certified under Medicare)
♦ Accredited mental health service providers
♦ Qualified brain injury professionals
"Family" may include spouse, children, friends, or in-laws of the member. It does not include people who are employed to care for the member.
Counseling may include the use of treatment regimens as specified in the individual treatment plan. Periodic training updates may be necessary to safely maintain the member in the community.

Counseling may include helping the member or family members with:
♦ Crisis
♦ Coping strategies
♦ Stress reduction
♦ Management of depression
♦ Alleviation of psychosocial isolation
♦ Support in coping with the effects of a brain injury

Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of a qualified provider.

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

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

A unit of service is one 15-minute increment. There is an upper rate limit that is subject to change on a yearly basis.

Payment for group counseling is based on a group rate divided by six or the actual number of members participating in the group if the number of participants exceeds six members.

Providers delivering this service via the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given when client needs include: accessibility, translation, or limited auditory or visual capacities are present;
•Have a contingency plan for provision of services if technology fails;
•Professionals do not practice outside of their respective scope; and
•Assessment of clients and caregivers that identifies a client's ability to participate in and outlines any accommodations needed while using Telehealth.

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 Agency (HHA)
Agency	Mental Health Service Provider
Individual	Hospice Provider
Agency	Agencies which are accredited by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider
Agency	Community Mental Health Centers
Individual	Qualified Brain Injury Professional

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Agency

Provider Type:

Home Health Agency (HHA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Home health aide providers certified by Medicare.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Agency

Provider Type:

Mental Health Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers for the services set forth in subrules 24.4(9) through 24.4(13) shall meet the standards in subrules 24.4(1) through 24.4(8) in addition to the standards for the specific service. Providers of outpatient psychotherapy and counseling services shall also meet standards in subrules 24.4(1), 24.4(2), 24.4(4), 24.4(6), 24.4(7), and 24.4(8)

Other Standard *(specify):*

Mental health service provider" means an organization whose services are established to specifically address mental health services to individuals or the administration of facilities in which these services are provided. Organizations included are:
1. Those contracting with a county board of supervisors to provide mental health services in lieu of that county's affiliation with a community mental health center (Iowa Code chapter 230A).
2. Those that may contract with a county board of supervisors for special services to the general public or special segments of the general public and that are not accredited by any other accrediting body.
These standards do not apply to individual practitioners or partnerships of practitioners covered under Iowa's professional licensure laws."

Providers for the services set forth in sub rules 24.4(9) through 24.4(13) shall meet the standards in sub rules 24.4(1) through 24.4(8) in addition to the standards for the specific service. Providers of outpatient psychotherapy and counseling services shall also meet standards in sub rules 24.4(1), 24.4(2), 24.4(4), 24.4(6), 24.4(7), and 24.4(8)."

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.
Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11).

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Individual

Provider Type:

Hospice Provider

Provider Qualifications

License *(specify):*

Providers liscensed and meeting the hospice standards and requirements set forth in the Deprtment of Inspection and Appeals rules IAC 481- chapter 53

Certificate *(specify):*

Providers certified to meet the standards under Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441 83.81(249A)

Other Standard *(specify):*

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department’s brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST). Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.
Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11).

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Agency

Provider Type:

Agencies which are accredited by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Accredited by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Agency

Provider Type:

Community Mental Health Centers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers certified as Community Mental Health Centers established by the MH/DD commission set forth in 441 IAC Chpater 24, Divisions I and II, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441-83.81(249A)

Other Standard *(specify):*

Providers for the services set forth in sub rules 24.4(9) through 24.4(13) shall meet the standards in sub rules 24.4(1) through 24.4(8) in addition to the standards for the specific service. Providers of outpatient psychotherapy and counseling services shall also meet standards in sub rules 24.4(1), 24.4(2), 24.4(4), 24.4(6), 24.4(7), and 24.4(8).

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Individual

Provider Type:

Qualified Brain Injury Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Meet the definition of qualified brian injury professional as set forth in rule IAC 441- 83.81 (249A)

Other Standard *(specify):*

“Qualified brain injury professional” means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two
years’ experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in psychology, sociology, or public health or rehabilitation services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Covered home and vehicle modifications are those physical modifications to the members home or vehicle listed below that directly address the members 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 greaterindependence in the home or vehicle.

Modifications that are necessary or desirable without regard to the members medical or remedial need and that would be expected to increase the fair market value of the home or vehicle,such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded. Purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle are excluded. Repairs include any action that is intended to restore to a good or sound condition after decay or damage. Manufacturer recommended upkeep and routine maintenance of the modifications are included.

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

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

There is an annual limit established for this service which is subject to change on a yearly basis.
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.
c. A unit of service is the completion of needed modifications or adaptations.
d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.
e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the member.
f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers compensation coverage.
g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.
h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services covered under durable medical equipment or specialized medical equipment.

Members enrolled in the waiver have access to Iowa’s Medicaid Exception to Policy option. ETPs can be requested to Iowa Administrative Code (IAC) rules but cannot be requested for Federal requirements or state law. Members needing additional services in order to ensure health, safety, or other issues can request ETPs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding ETP requests are approved by the Department of Health and Human Services director.

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	Agency
Agency	Community Business

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:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers meeting the requirements of 441 IAC Chapter 77.

Other Standard *(specify):*

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.

"For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this 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:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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):*

441 IAC 77.39(16)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 worker's compensation insurance.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this 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:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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 (IMMT)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11010 health monitoring
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults
whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by
a physician.

a. Need for service. The member must be currently receiving home health agency services
under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:
(1) To allow the member's usual caregivers to be employed,
(2) During a search for employment by a usual caregiver,
(3) To allow for academic or vocational training of a usual caregiver,
(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:
(1) Provide experiences for each member's 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. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

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

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

A maximum of 48 15 min units are available per day. The is an upper rate limit for the service which is subject to change on a yearly basis.

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 Agency
Agency	Supported Community Living provider
Agency	Child Care Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interim Medical Monitoring and Treatment (IMMT)

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

441—77.9(249A) Home Health agencies certified to participate in the Medicare program.

Other Standard *(specify):*

Staff members providing interim medical monitoring and treatment services
to members shall meet all of the following requirements:
1) Be at least 18 years of age, and
2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under, and
3) Not be a usual caregiver of the member, and
4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interim Medical Monitoring and Treatment (IMMT)

Provider Category:

Agency

Provider Type:

Supported Community Living provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

Other Standard *(specify):*

Staff members providing interim medical monitoring and treatment services
to members shall meet all of the following requirements:
1) Be at least 18 years of age, and
2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under, and
3) Not be a usual caregiver of the member, and
4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interim Medical Monitoring and Treatment (IMMT)

Provider Category:

Agency

Provider Type:

Child Care Facility

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Childcare facilities, which are defined as childcare centers, preschools, or child development. homes registered pursuant to 441 Chapter 110.

Other Standard *(specify):*

Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:
1) Be at least 18 years of age, and
2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under, and
3) Not be a usual caregiver of the member, and
4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:

Medical Day Care for Children

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04080 medical day care for children
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

This service provides supervision and support of children (aged 0-18) residing in their family home who, because of their complex medical or complex behavioral needs, require specialized exceptional care that cannot be served in traditional childcare settings. The need for the service must be medically necessary and verified in writing by the child's healthcare professional and documented in the child's service plan.

Specialized exceptional care means that the child has complex medical or behavioral health needs that require intensive assistance for monitoring and intervention including, but not limited to:
• The child has emotional or behavioral needs such as hyperactivity; chronic depression or withdrawal; bizarre or severely disturbed behavior; significant acting out behaviors; or the child otherwise demonstrates the need for intense supervision or care to ensure the safety of the child and those around him/her.
• The child has medical needs, such as ostomy care or catheterization; tube feeding or supervision during feeding to prevent complications such as choking, aspiration or excess intake; monitoring of seizure activity, frequent care to prevent or remedy serious conditions such as pressure sores; suctioning; assistance in transferring and positioning throughout the day; assistance with multiple personal care needs including dressing, bathing, and toileting; complex medical treatment throughout the day.
• The child has a complex and unstable medical condition that requires constant and direct supervision.
• The child has care needs exceeding the range of 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 which are necessary to assure the health and welfare of the child and avoid institutionalization.

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

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

The service shall be identified in the member's individual comprehensive service plan.
This service is limited to medically fragile children and children with complex behavioral health needs and may not be used to provide services that are the responsibility of the parent or guardian.
The services are provided outside periods when the child is in school.
Medical Day Care for Children when provided outside the member's home must be approved by the parent, guardian or primary caregiver, and the interdisciplinary team, and must be consistent with the way the location is used by the public.

Specialized childcare services shall not be simultaneously reimbursed with other residential or respite services, HCBS BI or ID Waiver Supported Community Living (SCL) services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), HCBS nursing, or Medicaid or HCBS home health aide services.

The scope of the Medical Day Care for Children services exceeds the scope of the categories of mandatory and optional services listed in section 1905(a). During the initial and annual person-centered planning meetings the Case Manager, Community-Based Case Manager, or Care Coordinator are responsible for ensuring that the child has accessed all available state plan services before requesting authorization for the HCBS waiver Medical Day Care for Children service on behalf of the child. The Waiver Prior Authorization reviewers for FFS and the MCO Utilization Management reviewers review service requests and service utilization to ensure that the member is first accessing all state plan services available before authorizing the service.

A unit of service is 15 minutes.

Members enrolled in the waiver have access to Iowa's Medicaid Exception to Policy option. ETPs can be requested to Iowa Administrative Code (IAC) rules but cannot be requested for Federal requirements or state law. Members needing additional services in order to ensure health, safety, or other issues can request ETPs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding ETP requests are approved by the Department of Health and Human Services director.

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 Agency
Agency	Child Care Facility
Agency	Home Care Agency
Agency	Supported Community Living Providers certified under the BI or ID Waiver
Agency	Respite Provides certified under the BI or ID Waivers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Day Care for Children

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):*

Medical Day Care for Children providers shall meet the following conditions:
Providers shall maintain the following information that shall be updated at least annually:
• The member's name, birth date, age, and address and the telephone number of the guardian or primary caregiver.
• An emergency medical care release.
• Emergency contact telephone numbers such as the number of the member's physician and the guardian, or primary caregiver.
• The member's medical issues, including allergies.
• The member's daily schedule which includes the member'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.

Policies shall be developed for:
• Notifying the parent, guardian, or primary caregiver of any injuries or illnesses that occur duringservice provision.
• A guardian's or primary caregiver's signature is required to verify receipt of notification.
• Requiring the parent, guardian, or primary caregiver to notify the service provider of any injuries or illnesses that occurred prior to service provision.
• Documenting of service provision. This documentation shall be made available to the parent, 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

Providers must be qualified by training and experience to deliver Medical Day Care for Children.

Direct support professionals delivering this service must be:
• at least 18 years of age.
• qualified by training and/or experience to deliver the service.
• not the spouse or guardian of the member, or a parent or stepparent of a member aged 17 or under.
• not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS.

This service may be delivered under the Consumer Choices Option (CCO).

CCO employees must be:
• at least 18 years of age.
• qualified by training and/or experience to provide the level of care required.
• not the guardian or a parent or stepparent of a member aged 17 or under.
• not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Day Care for Children

Provider Category:

Agency

Provider Type:

Child Care Facility

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Child Care Facilities that are defined as child care centers, preschools, or child development homes registered pursuant to 441 IAC chapter 110

Other Standard *(specify):*

Medical Day Care for Children providers shall meet the following conditions:
Providers shall maintain the following information that shall be updated at least annually:
• The member's name, birth date, age, and address and the telephone number of the guardian or primary caregiver.
• An emergency medical care release.
• Emergency contact telephone numbers such as the number of the member's physician and the guardian, or primary caregiver.
• The member's medical issues, including allergies.
• The member's daily schedule which includes the member'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.

Policies shall be developed for:
• Notifying the parent, guardian, or primary caregiver of any injuries or illnesses that occur duringservice provision.
• A guardian's or primary caregiver's signature is required to verify receipt of notification.
• Requiring the parent, guardian, or primary caregiver to notify the service provider of any injuries or illnesses that occurred prior to service provision.
• Documenting of service provision. This documentation shall be made available to the parent, 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

Providers must be qualified by training and experience to deliver Medical Day Care for Children.

Direct support professionals delivering this service must be:
• at least 18 years of age.
• qualified by training and/or experience to deliver the service.
• not the spouse or guardian of the member, or a parent or stepparent of a member aged 17 or under.
• not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS.

This service may be delivered under the Consumer Choices Option (CCO).

CCO employees must be:
• at least 18 years of age.
• qualified by training and/or experience to provide the level of care required.
• not the guardian or a parent or stepparent of a member aged 17 or under.
• not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Day Care for Children

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Eligible Home Care agencies are those that meet the conditions set forth in Iowa Administrative Code Chapter 77. a. Certified as a home health agency under Medicare, or b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

Other Standard *(specify):*

Medical Day Care for Children providers shall meet the following conditions:
Providers shall maintain the following information that shall be updated at least annually:
• The member's name, birth date, age, and address and the telephone number of the guardian or primary caregiver.
• An emergency medical care release.
• Emergency contact telephone numbers such as the number of the member's physician and the guardian, or primary caregiver.
• The member's medical issues, including allergies.
• The member's daily schedule which includes the member'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.

Policies shall be developed for:
• Notifying the parent, guardian, or primary caregiver of any injuries or illnesses that occur duringservice provision.
• A guardian's or primary caregiver's signature is required to verify receipt of notification.
• Requiring the parent, guardian, or primary caregiver to notify the service provider of any injuries or illnesses that occurred prior to service provision.
• Documenting of service provision. This documentation shall be made available to the parent, 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

Providers must be qualified by training and experience to deliver Medical Day Care for Children.

Direct support professionals delivering this service must be:
• at least 18 years of age.
• qualified by training and/or experience to deliver the service.
• not the spouse or guardian of the member, or a parent or stepparent of a member aged 17 or under.
• not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS.

This service may be delivered under the Consumer Choices Option (CCO).

CCO employees must be:
• at least 18 years of age.
• qualified by training and/or experience to provide the level of care required.
• not the guardian or a parent or stepparent of a member aged 17 or under.
• not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Day Care for Children

Provider Category:

Agency

Provider Type:

Supported Community Living Providers certified under the BI or ID Waiver

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):*

Medical Day Care for Children providers shall meet the following conditions:
Providers shall maintain the following information that shall be updated at least annually:
• The member's name, birth date, age, and address and the telephone number of the guardian or primary caregiver.
• An emergency medical care release.
• Emergency contact telephone numbers such as the number of the member's physician and the guardian, or primary caregiver.
• The member's medical issues, including allergies.
• The member's daily schedule which includes the member'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.

Policies shall be developed for:
• Notifying the parent, guardian, or primary caregiver of any injuries or illnesses that occur duringservice provision.
• A guardian's or primary caregiver's signature is required to verify receipt of notification.
• Requiring the parent, guardian, or primary caregiver to notify the service provider of any injuries or illnesses that occurred prior to service provision.
• Documenting of service provision. This documentation shall be made available to the parent, 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

Providers must be qualified by training and experience to deliver Medical Day Care for Children.

Direct support professionals delivering this service must be:
• at least 18 years of age.
• qualified by training and/or experience to deliver the service.
• not the spouse or guardian of the member, or a parent or stepparent of a member aged 17 or under.
• not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS.

This service may be delivered under the Consumer Choices Option (CCO).

CCO employees must be:
• at least 18 years of age.
• qualified by training and/or experience to provide the level of care required.
• not the guardian or a parent or stepparent of a member aged 17 or under.
• not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Day Care for Children

Provider Category:

Agency

Provider Type:

Respite Provides certified under the BI or ID 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):*

Medical Day Care for Children providers shall meet the following conditions:
Providers shall maintain the following information that shall be updated at least annually:
• The member's name, birth date, age, and address and the telephone number of the guardian or primary caregiver.
• An emergency medical care release.
• Emergency contact telephone numbers such as the number of the member's physician and the guardian, or primary caregiver.
• The member's medical issues, including allergies.
• The member's daily schedule which includes the member'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.

Policies shall be developed for:
• Notifying the parent, guardian, or primary caregiver of any injuries or illnesses that occur duringservice provision.
• A guardian's or primary caregiver's signature is required to verify receipt of notification.
• Requiring the parent, guardian, or primary caregiver to notify the service provider of any injuries or illnesses that occurred prior to service provision.
• Documenting of service provision. This documentation shall be made available to the parent, 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

Providers must be qualified by training and experience to deliver Medical Day Care for Children.

Direct support professionals delivering this service must be:
• at least 18 years of age.
• qualified by training and/or experience to deliver the service.
• not the spouse or guardian of the member, or a parent or stepparent of a member aged 17 or under.
• not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS.

This service may be delivered under the Consumer Choices Option (CCO).

CCO employees must be:
• at least 18 years of age.
• qualified by training and/or experience to provide the level of care required.
• not the guardian or a parent or stepparent of a member aged 17 or under.
• not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, Provider Services Unit

Frequency of Verification:

Every five 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 System or Portable Locator System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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.

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

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	Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System or Portable Locator System

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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.

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.

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.

The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

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:

The Dept. of Human services to The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:**
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02023 shared living, other
Category 3:	**Sub-Category 3:**
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supported community living (SCL) services are provided within the member's home and community, according to the individualized member's need as identified in the service plan. Available components 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 mean 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 mean activities and expenditures provided to or on behalf of a person in the areas of personal needs to allow the person to function in the least restrictive environment.

Transportation services means activities and expenditures designed to assist the person to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from medical services. Members needing transportation to and from medical services must use the state plan medical transportation 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 to maintain or improve the person's functioning in response to the physical, emotional, and social environment.

Remote Support SCL Service Delivery Model

Remote Support is the provision of SCL by a trained remote support professional who is in a remote location and is engaged with a person through enabling technology that utilizes live two-way communication in addition to or in place of on-site staffing. Remote support is not a service. It is an available delivery option through the SCL service to meet an individual's health, safety and other support needs as needed when it:
•Is chosen and preferred as a service delivery method by the person or their guardian (if applicable)
•Appropriately meets the individual's assessed needs.
•Is provided within the scope of the service being delivered.
•Is provided as specified in the individual's support plan.

Remote supports are delivered by awake; alert remote support professionals whose primary duties are to provide remote supports from the provider's secure remote supports location. To ensure safety and Health Insurance

Portability and Accountability Act (HIPAA) compliance, this location should have appropriate, stable, and redundant connections. This should include, but is not limited to, backup generators or back battery, multiple internet service connections.

Remote supports may be used with either paid or unpaid backup support as specified in the individual's service plan. Paid backup support is provided on a paid basis by a provider of SCL that is both the primary point of contact for the remote supports vendor and the entity to send paid staff person(s) on-site when needed. Unpaid backup support may be provided by a family member, friend, or other person who the individual chooses. The person-centered service plan (PCSP) will reflect how the remote supports are being used to meet the goals for independent living and assessed needs, including health, safety and welfare needs.

Remote Support Service Requirements

Assessment
Through an assessment by the SCL remote support provider with input from the individual and their Interdisciplinary Team (IDT) the member's ability to be supported safely through remote support is identified and the location of the devices or monitors will be determined to best meet the individual's needs.
The assessment is provided as a part of the person-centered planning process and included in the administrative cost of waiver services.

Informed Consent
Informed consent by the individual using the service, their guardian and other individuals and their guardians residing in the home must be obtained and clearly state the parameters in which the remote support service would be used.
Each individual, guardian and IDT must be made aware of both the benefits and risks of the operating parameters and limitations.
Informed consent documents must be acknowledged in writing, signed, and dated by the individual, guardian, case manager (CM) and provider agency representative, as appropriate. A copy of the consent shall be maintained by the CM, the guardian (if applicable) and in the home file.

If the individual desires to withdraw consent, they would notify the CM. As informed consent is a prerequisite for utilization of remote support services, a meeting of the IDT would be needed to discuss available options for any necessary alternate supports. All residing adult and youth individuals, their guardians and their support teams impacted by the decision to withdraw consent must be immediately informed of the decision and use of remote supports in the setting must be discontinued.

Informed consent for remote supports must be reviewed annually as part of the person-centered planning process.

Privacy
Remote Support Professionals must:
*Respect and always maintain the individual's privacy, including when the person is in settings typically used by the public.
*Respect and always maintain the individual's privacy, including when scheduled or intermittent/as-needed support includes responding to an individual's health, safety and other support needs for personal cares.
*Only use cameras in bedrooms or bathrooms when the IDT has identified a specific support need in the person-centered service plan and the member, and their legal representative has given informed consent.

The agency service provider responsible for responding to an individual's health, safety, and other support needs through remote support must:
1.Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA)
2.Comply with the data privacy laws, restrictions and guidelines.
3.Ensure that service documentation occurs during remote support delivery in accordance with the 441-79.3

See Main: B. Optional for additional information regarding SCL delivered through remote support and telehealth.

Host Home SCL Service Delivery Model

A Host Home is a community-based family home setting whose owner or renter provides home and community-based services (HCBS) Waiver SCL services to no more than 2 individuals who reside with the owner or renter in their primary residence and is approved for those services as an independent contractor of a community-based SCL service agency.

Host Home is an available delivery option through the SCL service to meet a member's health, safety and other support needs as needed when it:
*Is chosen and preferred as a service delivery method by the person or their guardian (if applicable)
*Appropriately meets the member's assessed needs.
*Is provided within the scope of the service being delivered.
*Is provided as specified in the member's support plan.

Service Requirements

Assessment
Through an assessment by the SCL agency provider with input from the member and their Interdisciplinary Team (IDT); the member's ability to be supported safely through the Host Home model is identified, the desired location of the Host Home will be determined to best meet the member's needs, and potential matching Host Homes will be identified.

Informed Consent
Informed consent of delivery of SCL in the Host Home by the Host Home provider by the individual using the service, their guardian must be obtained.
Each member, guardian and IDT must be made aware of both the benefits and risks of the Host Home service delivery model.
Informed consent documents must be acknowledged in writing, signed, and dated by the individual, guardian, CM and provider agency representative, as appropriate. A copy of the consent shall be maintained by the CM, the guardian (if applicable) and in the provider agency file.
If the individual desires to withdraw consent, sever the residential agreement, and transfer from the Host Home to a provider owned and controlled SCL setting, the member, their guardian or the Host must notify the SCL provider agency and the member's CM. A meeting of the IDT would be needed to discuss available options for any necessary alternative services and supports.

Privacy
Host Home SCL service providers must:
* Respect and always maintain the member's privacy, including when the person is in settings typically used by the public.
* Respect and always maintain the member's privacy, including when scheduled or intermittent/as-needed support includes responding to a member's health, safety and other support needs for personal cares.

Providers delivering this service via the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given when client needs include: accessibility, translation, or limited auditory or visual capacities are present;
•Have a contingency plan for provision of services if technology fails;
•Professionals do not practice outside of their respective scope; and
•Assessment of clients and caregivers that identifies a client's ability to participate in and outlines any accommodations needed while using Telehealth.

In-person contact is not required as a prerequisite for payment.

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

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 7-day week and the member's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision. The cost per unit is capped at the average ICF/ID rate calculated retrospectively each year. If the member's needs exceed the upper rate limit allowed in rule, Members may request an exception to policy to exceed the upper rate limit allowed in administrative rule.
(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 441 - 77.79(1).

For daily unit reimbursement, the provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The cost of transportation may be included in the rate of the services as allowed by rule. The specific support needs must be identified in the Medicaid case manager'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) 11,315 15-minute units are available per state fiscal year except a leap year when 11,336 15-minute units are available.
The service shall be identified in the member's comprehensive service plan.
Services shall not be simultaneously reimbursed with other residential services, HCBS respite, Medicaid nursing, or Medicaid or HCBS home health aide services.

SCL delivered through Remote Support
Providers may not bill for direct support delivered remotely when real-time monitoring or two-way communication does not occur (e.g., leaving a voicemail, sending a FAX, sending an email, internet outage, etc.)
Internet connectivity costs and phone service costs are not included in the SCL reimbursement rate.

SCL delivered in a Host Home
Agency Providers may only bill for direct support delivered in the Host Home or community when the member is receiving SCL from an approved contractor or subcontractor in accordance with the person-centered service plan and there is supporting documentation of service delivery.

Members enrolled in the waiver have access to Iowa's Medicaid Exception to Policy option. ETPs can be requested to Iowa Administrative Code (IAC) rules but cannot be requested for Federal requirements or state law. Members needing additional services in order to ensure health, safety, or other issues can request ETPs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding ETP requests are approved by the Department of Health and Human Services director.

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 Family Home Subcontractors
Agency	Licensed Foster Care

Provider Category	Provider Type Title
Agency	Certified Supported Community Living Providers

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):*

Providers must meet the requirements and standards in 441-77.39

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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):*

Other Standard *(specify):*

Providers must meet the requirements and standards in 441-77.39

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five year

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):*

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):*

The following are requirements of a remote supports system design when utilized to replace in-person direct support service delivery:
• The provider must have safeguards and/or backup system such as battery or generator for the electronic devices in place at the remote supports monitoring location and the individual's home in the event of electrical outages.
• The provider must have written policy and procedures approved by the Iowa Medicaid Quality Improvement Organization (QIO) HCBS unit that defines emergency situations and details.
o How remote and backup staff will respond to each. Examples include:
o Fire, medical crises, stranger in the home, violence between individuals and any other situation that appears to threaten the health or welfare of the individual.
o Emergency response drills must be carried out once per quarter per shift in each home.
equipped with and capable of utilizing remote supports.
Documentation of the drills must be available for review upon request.
o When used to replace in-person direct support service delivery, the remote monitoring staff shall generate service documentation on each individual for the period when remote supports are provided.
• The provider must have backup procedures for system failure (for example, prolonged power outage), fire or weather emergency, individual medical issue or personal emergency in place and detailed in writing for each site utilizing the system as well as in each individual's PCSP. This plan should specify the staff person or persons to be contacted by remote support monitoring staff who will be responsible for responding to these situations and traveling to the individual's home, including any previously identified paid or unpaid backup support responder.
• The remote supports system may receive notification of smoke/heat alarm activation. Recognizing remote supports will vary based on individual needs assessments, notifications are not intended to replace fire/smoke/heat detection systems nor drills as required..
The remote support system must have in place regular routine of testing that ensures the system and devices are working properly.
• The remote supports system must have two-way (at minimum, full duplex) audio communication capabilities to allow monitoring staff to effectively interact with and address the needs of individuals in each living site, including emergency situations when the individual may not be able to use the telephone.
• The remote supports system may allow the monitoring base staff to have visual (video) oversight of areas in individual's residential living sites as deemed necessary by the IDT to meet the individual's needs based on informed consent of the member and/ or their legal representative.
• A remote supports monitoring base may not be located in the home of the individual receiving remote support.
• A secure (compliant with the HIPAA) network system requiring authentication, authorization and encryption of data must be in place to ensure access to computer vision, audio, sensor, or written information is limited to authorized individuals identified in the member's service plan, and state entities as necessary for the oversight of service delivery.
• The members must be made aware of the operating hours of the equipment
• For situations involving remote supports of individuals needing 24-hour support, if an individual indicates that they no longer want to receive their service through the remote supports system the following protocol will be implemented:
– The remote support professional or other person who becomes aware of the member's desire to change to all in person supports will notify the provider to request an IDT meeting to discuss the request and identify appropriate alternative

Remote Support Professionals that will only provide remote support shall be trained commensurate with the needs of the individuals and shall receive the following training at a minimum:
• Dependent adult abuse reporting
• Incident Reporting
• Member Rights
• Provider's Remote Support Policies and Procedures
• Individual member remote support protocols
Remote support professional who will also deliver in person supports and are responsible for responding to a person's health, safety and other support needs through remote support shall be trained commensurate with the needs of the individuals and shall receive the following training at a minimum:

• Dependent adult abuse reporting
• Incident Reporting
• Member Rights
• Individual member remote support protocols/ person-centered service plans
• Provider's Remote Support Policies and Procedures
• Meet the Supported Community Living staff qualifications in 441 Iowa Administrative Code Chapter 77.

Host Home providers delivering SCL services must:
• Meet the staff qualifications in 441 Iowa Administrative Code Chapter 77.
• Receive pre-service training:
• The philosophy of HCBS, including HCBS settings requirements and expectations
• The organization's mission, policies, and procedures
• The organization's policy related to identifying and reporting abuse.
• Preventing, detecting, and reporting of abuse/neglect, Child and/or Dependent Adult Abuse and Mandatory Reporting prior to providing direct care (additional training at least every 3 years after the initial training)
• Members' rights including outcomes for rights and dignity as applicable.
• Restrictive interventions (restraints, rights restrictions, and behavioral intervention)
• Individual members' support needs (prior to serving the member and as updates
• Specific behavior support or de-escalation curriculum such as Mandt, Safety-Care, PBIS, CPI, or other
• Confidentiality and safeguarding member information
• The organization's policy related to member's medication.
• An approved Medication Manager training for any contractors that are administering controlled substances.
• Identifying and reporting incidents
• Service documentation
• The state designated Traumatic Brain Injury Training within 60 days of providing BI Waiver services

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized. The case manager responsible for service plan development and authorization will identify the availability of alternative sources of transportation in the member's comprehensive service plan.
This service does not include transportation to Medicaid covered medical services which is provided under the state plan covered benefit called Non Emergency Medical Transportation (NEMT).

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

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

A unit of service is either per mile, per trip. Transportation may not be reimbursed simultaneously with any other transportation service and may not be duplicative of any transporation service provided under the State plan.
Transportation shall not be reimbursed simultaneously with supported community living services when the SCL rate paid to provider includes the cost of member's transportation.
There is an upper rate limit that is subject to change on a yearly basis.

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	Area Agency on Aging
Agency	Non-Emergency Medical Transporation Provider contracted with the NEMT Broker
Agency	Regional Transit Agency
Agency	Community Action Agency
Agency	Nursing Facilities
Agency	Transportation Provider
Agency	HCBS Provider Agencies

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 Agency on Aging

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Area agencies on aging as designated in 17 IAC 4.4(231):Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following:
a.An established office of aging operating within a planning and service area;
b.Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit;
c.Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose;
d.Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which for designation purposes is under the supervision or direction of the department and which can and will engage only in the planning or provision of a broad range of supportive services or nutrition services within such planning and service area; or
e.Any other entity authorized by the Older Americans Act.
or
2)with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

Other Standard *(specify):*

77.37(24) Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.
b. Regional transit agencies as recognized by the Iowa department of transportation.
c. Transportation providers that contract with county governments.
d. Community action agencies as designated in Iowa Code section 216A.93.
e. Nursing facilities licensed under Iowa Code chapter 135C.
f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
g. Transportation providers contracting with the nonemergency medical transportation contractor.

Area agencies on aging as designated in 3214.4(231). Transportation 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:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:

Non-Emergency Medical Transporation Provider contracted with the NEMT Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

441 IAC 77.39(18)

Other Standard *(specify):*

77.37(24) Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.
b. Regional transit agencies as recognized by the Iowa department of transportation.
c. Transportation providers that contract with county governments.
d. Community action agencies as designated in Iowa Code section 216A.93.
e. Nursing facilities licensed under Iowa Code chapter 135C.
f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
g. Transportation providers contracting with the nonemergency medical transportation contractor.

Request for Proposal for Contract Award: The Broker will utilize Public Transit agencies, private transportation agencies and individuals. The network of providers may also include other transportation alternatives, such as the services of volunteers, taxis, wheelchair vans, stretcher vans, ambulances, and air ambulances (fixed wing and rotary). All transportation is to be provided with an occupant protection system that addresses the safety needs of the disabled or special needs individuals.
The Broker will be required to ensure that all eligible Medicaid Members receive transportation services that are safe, reliable and on time by providers who are licensed, qualified, competent, and courteous.

The Department's Contract Administrator for Iowa Medicaid is the principal contact with the transportation Broker. The Department's Contract Administrator is responsible for monitor the contract performance and compliance with contract terms and conditions.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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 Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

As designated by the Iowa Department of Transportation in the Code of Iowa 28M.

Other Standard *(specify):*

77.37(24) Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.
b. Regional transit agencies as recognized by the Iowa department of transportation.
c. Transportation providers that contract with county governments.
d. Community action agencies as designated in Iowa Code section 216A.93.
e. Nursing facilities licensed under Iowa Code chapter 135C.
f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
g. Transportation providers contracting with the nonemergency medical transportation contractor.

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:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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):*

Community action agencies as designated in Iowa Code section 216A.93.

Other Standard *(specify):*

77.37(24) Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.
b. Regional transit agencies as recognized by the Iowa department of transportation.
c. Transportation providers that contract with county governments.
d. Community action agencies as designated in Iowa Code section 216A.93.
e. Nursing facilities licensed under Iowa Code chapter 135C.
f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
g. Transportation providers contracting with the nonemergency medical transportation contractor.

"Community action agency" means a public agency or a private nonprofit agency which is authorized under its charter or bylaws to receive funds to administer community action programs and is designated by the governor to receive and administer the funds Establishment of community action agencies.
The division shall recognize and assist in the designation of certain community action agencies to assist in the delivery of community action programs. These programs shall include but not be limited to outreach, community services block grant, low-income energy assistance, and weatherization programs.
If a community action agency is in effect and currently serving an area, that community action agency shall become the designated community action agency for that area. If any geographic area of the state ceases to be served by a designated community action agency, the division may solicit applications and assist the governor in designating a community action agency for that area in accordance with current community services block grant requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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):*

Nursing facilities are licensed by the Department of Inspections and Appeals under 481 IAC Chapters 58, and 61.

Certificate *(specify):*

Other Standard *(specify):*

77.37(24) Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.
b. regional transit agencies as recognized by the Iowa department of transportation.
c. Transportation providers that contract with county governments.
d. Community action agencies as designated in Iowa Code section 216A.93.
e. Nursing facilities licensed under Iowa Code chapter 135C.
f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
g. Transportation providers contracting with the nonemergency medical transportation contractor.

Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.
(1) Procedures for establishing health care facilities as Medicaid facilities. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "State Operations Manual."
a. The facility shall obtain the applicable license from the department of inspections and appeals and must be recommended for certification by the department of inspections and appeals.
b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid provider services unit.
c. The Iowa Medicaid provider services unit shall transmit an application form and a copy of the nursing facility provider manual to the facility.
d. The facility shall complete its portion of the application form and submit it to the Iowa Medicaid provider services unit.
e. The Iowa Medicaid provider services unit shall review the application form and verify with the department of inspections and appeals that the facility is licensed and has been recommended for certification.
f. Prior to requesting enrollment, the facility shall contact the department of inspections and appeals to schedule a survey. The department of inspections and appeals shall schedule and complete a survey of the facility.
g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.
h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.
i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.
j. When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.
(2) Medicaid provider agreements. The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification

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:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during

respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
c. 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.
d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:

Transportation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

441-IA 77.39(18)

Other Standard *(specify):*

Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.
b. Regional transit agencies as recognized by the Iowa department of transportation.
c. Transportation providers that contract with county governments.
d. Community action agencies as designated in Iowa Code section 216A.93.
e. Nursing facilities licensed under Iowa Code chapter 135C.
f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
g. Transportation providers contracting with the nonemergency medical transportation contractor.

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. 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:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five 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:

HCBS Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified or Accredited enrolled HCBS providers under441 IAC Chpater 24 and/ or Chapter 77

Other Standard *(specify):*

77.37(24) Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.
b. Regional transit agencies as recognized by the Iowa department of transportation.
c. Transportation providers that contract with county governments.
d. Community action agencies as designated in Iowa Code section 216A.93.
e. Nursing facilities licensed under Iowa Code chapter 135C.
f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
g. Transportation providers contracting with the nonemergency medical transportation contractor.
Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist
(CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.
Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.
In addition, supported community living, providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Organizational standards (Outcome 1). Organizational outcome-based standards for
HCBS BI providers are as follows:
a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.
b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.
c. The organization establishes and maintains fiscal accountability.
d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.
e. The organization provides needed training and supports to its staff. This training includes at a minimum:
(1) Consumer rights.
(2) Confidentiality.
(3) Provision of consumer medication.
(4) Identification and reporting of child and dependent adult abuse.
(5) Individual consumer support needs.
f. The organization has a systematic, organization wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:
(1) Measures and assesses organizational activities and services annually.
(2) Gathers information from consumers, family members, and staff.
(3) Conducts an internal review of consumer service records, including all major and minor incident

reports according to subrule 77.37(8).
(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.
(5) Identifies areas in need of improvement.
(6) Develops a plan to address the areas in need of improvement.
(7) Implements the plan and documents the results.
g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.
h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.
i. The governing body has an active role in the administration of the agency.
j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

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
Targeted case managers or integrated health home coordinators provide case management services to those fee-for-service participants enrolled in the State's §1915(c) Brain Injury, Waiver.

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 or integrated health home care coordinators 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. HHS approves and monitors all MCO policies and procedures to ensure compliance.

Payment will be approved for targeted case management services for members of the following populations who are not enrolled in an IA Health Link Managed
Care Organization (MCO), not eligible for MCO enrollment, or not enrolled in an Integrated Health Home (IHH):
Medicaid members who are 18 years of age or over and have a primary diagnosis of:
• Intellectual disability, or
• Developmental disabilities, or
• Chronic mental illness.
Payment will be approved for Waiver Case Management and care coordination for BI Waiver members who are not enrolled in an IA Health Link Managed Care Organization
(MCO) or who are not eligible for MCO enrollment and are not eligible for Targeted Case Management.

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. "Consumer" 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 consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer 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 Health and 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. Iowa Medicaid 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.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. Site visits occur following provider enrollment, during targeted reviews and during the full onsite review. 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. HHS 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. "Consumer" 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 consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer 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 others services must be provided by agency providers. Individual CDAC providers have child and dependent adult abuse background checks completed by the Iowa Medicaid Provider Services unit 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 Health and Human Services maintains the Central Abuse Registry. All child and dependent adult abuse checks are conducted by the HHS 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 HHS 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. HHS 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). HHS 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)

Note: Required information from this page is contained in response to C-5.

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 a waiver member. This applies to spouses, 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 aged 17 and younger may also be paid providers of service. The person who is legally responsible for an member may be an employee o subcontractor of a Supported Community Living (SCL) provider agency, Consumer Directed Attendant Care (CDAC) agency, an enrolled Individual Consumer Directed Attendant Care (ICDAC) provider or an employee under the Consumer Choices Option (CCO) program. When the legally responsible person is the SCL, CDAC or CCO employee, 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 legally responsible person is an employee through an SCL, CDAC or CCO, the legally responsible person must have the skills needed to provide the services to the member. In many situations, the member requests the legally responsible person to provide services, as the legally responsible person 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 HHS 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 HHS 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 those services rendered match the service plan and claim process. In addition, information on paid claims for fee-for-service members are available in IoWANS for review. The IoWANS 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 participants 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 participant 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 HHS maintains oversight of the MCO program integrity plans and responsibility for overall quality monitoring and oversight.

☒ **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, 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 aged 18 and over for whom they act as the legal representative. The legal representative may be an Individual CDAC provider, an employee under the CCO program, or an employee hired by a provider agency. When the legal representative is the SCL, 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 ICDAC 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 another 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 HHS 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 IoWANS for review. The IoWANS 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 those 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.

○ **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. Iowa Medicaid 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 county and State service workers, case managers, health home coordinators, market to qualified providers to enroll in Medicaid.

MCOs are responsible for oversight of their provider networks.
The State ensures that LTSS providers are given the opportunity for continued participation in the managed care networks by regularly monitoring the managed care organization provider network and evaluating rationales for not having providers in their networks. While the number of providers not contracted with all three managed care organizations is small, the rationale includes providers not accepting the "floor" rates determined by the State and wanting enhanced rates. The State additionally tracks on provider inquiries and complaints which includes complaints related to network access and credentialing.

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: Number and percent of newly enrolled waiver providers verified against the appropriate licensing or certification standards prior to furnishing services. Numerator=#of newly enrolled waiver providers verified against appropriate licensing or certification standards prior to furnishing services; Denominator=# of newly enrolled waiver providers required to be licensed or certified.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(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 =
☒ **Other** Specify: Contracted entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Encounter data, claims data and enrollment information out of IoWANS. All MCO HCBS providers must be enrolled as verified by Iowa Medicaid PS.

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 =
☒ **Other** Specify: Contracted entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-a2:Number and percent of licensed/certified waiver provider re-enrollments verified against the appropriate licensing/certification standards prior to continuing to furnish services. See Main B. Optional section for full description of PM, including the numerator and denominator.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:
Re-enrollment information out of IoWANS. All MCO HCBS Providers must be re-enrolled as verified by Iowa Medicaid Provider Services unit every 5 years.

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 =
☒ **Other** Specify: Contracted entity	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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: 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 direct service delivery; Denominator = # of non-licensed/noncertified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Enrollment Records, IoWANS, Claims

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 =
☒ **Other** Specify: Contract Entity	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **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:
QP-b2: 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 direct service delivery Denominator = number of CCO providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Financial Management Services (FMS) provider data collection

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 =
☒ **Other** Specify: FMS Provider	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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: Number and percent of HCBS providers that meet training requirements as outlined in State regulations and the approved waiver. Numerator = # of HCBS providers that meet training requirements as outlined in State regulations and the approved waiver; Denominator = # of HCBS 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 =
☒ **Other** Specify: Contracted	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

Iowa Medicaid Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment.
All MCO providers must be enrolled as verified by Iowa Medicaid Provider Services.

The Home and Community Based Services (HCBS) quality oversight unit is responsible for reviewing provider records at a 100% level over a three to five year cycle, depending on certification or accreditation. If it is discovered that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated if noncompliance persists.

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 Iowa Medicaid Provider Services, so if the provider is no longer enrolled by the Iowa Medicaid then that provider is no longer eligible to enroll with an MCO.

If it is discovered during HCBS Quality Oversight Unit review that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated is noncompliance persists.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and required changes in individual provider policy.

PMs QP-a1, QP-a2, QP-b1, QP-b2, QP-b3 discovery process includes reviewing the provider's qualifications prior to enrollment and upon reenrollment. Provider qualifications include ensuring that the provider is performing child and dependent adult abuse checks and criminal record checks in accordance with Code of Iowa 135C.33 https://www.legis.iowa.gov/docs/code/2019/135C.33.pdf, 441 Iowa Administrative Code 79.14 https://www.legis.iowa.gov/docs/iac/chapter/441.79.pdf and 441 IAC 119 https://www.legis.iowa.gov/docs/iac/chapter/09-25-2019.441.119.pdf

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**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: contracted entity and MCO	☐ **Annually**
	☐ **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 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.

Total monthly cost of all supported employment services may not exceed the amount identified in 441 Iowa Administrative Code 78.27(10)(e)(2). The total monthly cost limit for supported employment is based on historical experience and is adjusted based on direct appropriation from the legislature to increase reimbursement rates.

441 IAC 1.8(17A, 217) provides for waiver of administrative rules in exceptional circumstances.

Members are informed of the service limitations during the service planning process by their case manager, integrated health care coordinator, community-based case manager, and/or service provider. The member is also given written notice of the limitations in the HCBS BI Waiver Informational Packet as well as the HCBS Program Comparison chart.

☐ **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.

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, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

HCBS services can be provided in the following settings:

-Individual member's homes of any type (houses, apartments, condominiums, etc.).
-Members living in their family home of any type.
-Integrated community rental properties available to anyone within the community.
-Nonresidential Habilitation services including Day Habilitation, Prevocational, and Supported Employment services occur in integrated community-based settings.
-Adult Day Care may occur in the member's home or in integrated community-based settings.
-100% community-based "no walls" day habilitation services.

Provider-owned or controlled residential settings including:
-DIA licensed Residential Care Facility (RCF)
-DIA licensed Assisted Living Facility
- Host Home
-Supported Community Living Daily Site

In order to assess the settings identified above to ensure they met the HCBS settings requirements, Iowa Medicaid used their existing processes and enhanced, expanded, or created new processes and tools where gaps existed.
These processes include:
-Provider quality self-assessment, address collection, and attestation (form #470-4547)
-Quality oversight and review and specifically the SFY17-18 and SFY23 Focused Reviews completed by the QIO HCBS Unit
-Residential Assessments
-Settings Assessments

To ensure settings identified above continue to meet the HCBS settings requirements, Iowa Medicaid will use the following processes to assess HCBS settings for compliance with the Final Statewide Transition Plan (STP):
-Provider Quality Self-Assessment tool
-Quality oversight and review of non-residential settings completed by the QIO HCBS Unit.
-Residential Assessments – completed annually by case managers with each member receiving HCB services. Additionally, a Residential Assessment will be completed with members within 30 days of moving to a new residence.

All residential settings where HCB services are provided must document the following in the member's service or treatment plan:

-The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS at 42 CFR §441.301(c)(4)(i) (entire criterion except for "control personal resources), and receive services in the community, like individuals without disabilities.

-The setting, to reside in, is selected by the individual from setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board at 42 CFR §441.301(c)(4)(ii),

-Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact at 42 CFR §441.301(c)(4)(iv), and

-Facilitates individual choice regarding services and supports, and who provides them at 42 CFR §441.301(c)(4)(v).

Provider-owned or controlled residential settings:
Residential settings that are provider owned or provider controlled or operated including licensed Residential Care Facilities (RCF) for 16 or fewer persons must also document the following in the member's service or treatment plan:

-Individuals sharing units have a choice of roommate in that setting at 42 CFR §441.301(c)(4)(vi)(B)(2), and

-Individuals have the freedom and support to control their own schedules and activities at 42 CFR §441.301(c)(4)(vi)(C) (entire criterion except for "have access to food at any time").

HCBS services may not be provided in settings that are presumed to have institutional qualities and do not meet the rule's requirements for home and community-based settings. These settings include those in a publicly or privately-owned facility that provide inpatient treatment, on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.