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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Home and Community Based Services - Intellectual Disabilities (ID) Waiver

C. Waiver Number:IA.0242
Original Base Waiver Number: IA.0242.

D. Amendment Number:

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

01/01/25

Approved Effective Date of Waiver being Amended: 07/01/24

2. Purpose(s) of Amendment

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

Update the participant survey tool being used from the IPES (Iowa Participant Experience Survey) to the CAHPS (Consumer Assessment of Healthcare Providers and Systems) Home and Community-Based Services Survey. By changing the survey tool being used three of the current performance measures also had to be re-written. SP-c1 and SP-e1.

Currently, the Iowa Intellectual Disabilities (ID) waiver uses the Supports Intensity Scale-Adult Version (SIS-A) and the Supports Intensity Scale-Children's Version (SIS-C) to identify the supports children and adults need to live and thrive in the community. The SIS-A is used for adults ages 16 and older, and the SIS-C is used for children ages 5 through 15.

The SIS-A and the SIS-C are used for eligibility, service planning and to assign a tiered reimbursement rate based on a person's level of need. These tiered rates apply to a subset of services available under the waiver and include Daily Supported Community Living (SCL), Full day Day Habilitation, Full day Adult Day Care, and Residential Based SCL (RBSCL).

The American Association on Intellectual and Developmental Disabilities (AAIDD) released the first edition (version 1.0) of SIS-A in 2004. A second edition was released in January 2023 (version 2.0). AAIDD will retire the first edition in mid-2024 but provided Iowa Department of Health and Human Services (HHS) an additional 6 months to use the first version of the tool. Iowa HHS is required to discontinue use of the first edition by the end of 2024.

As a result, Iowa HHS will transition from SIS-A to the interRAI-Intellectual Disability (interRAI-ID) and from SIS-C to the interRAI-Child and Youth Mental Health -Developmental Disability (ChYMH-DD). To inform the transition to these two interRAI tools, Iowa HHS conducted a parallel assessment to test the utility of the interRAI-ID and ChYMH-DD to create tiers.

From June 17, 2024 to July 12, 2024, assessors completed the interRAI-ID or the ChYMH-DD for a portion of ID waiver enrollees with an off-year assessment in April or May 2024. The sample consisted of 76 interRAI assessments with corresponding SIS records. A decision tree model was trained to associate the scores from responses in various sections of the interRAI-ID assessments with the tier provided from the corresponding SIS-A assessments.

The model achieved an overall accuracy of 71% when tested on a sample of 56 combined actual assessments and simulated assessments containing 9-10 assessments in each tier. When tested on a sample of actual assessments only (i.e. excluding the synthetically produced assessments), the model achieved 60% overall accuracy, with 78% accuracy in identifying tier 6, and correctly classifying both the tier 1 and tier 5 assessments.

There are several limitations due to the low number of available assessments. There were not enough tier 1 to tier 5 assessments to recreate these tiers using the interRAI that match the SIS tiers with 100% accuracy. Due to these limitations, Iowa HHS intends to recalibrate the methodology as interRAI assessments are completed over time to increase accuracy.
To further mitigate any risks to the tiered reimbursement rate assignment associated with this change in assessment, Iowa HHS will do the following:
•For reassessments when there is no change in condition: Hold current waiver enrollees at the tier approved in the prior waiver year, even if the use of the interRAI-ID or ChYMH-DD produces a tier lower or higher than approved in the prior waiver year.
•For reassessments when there is a change of condition: Move the enrollee to the tier assigned by the interRAI-ID or ChYMH-DD after Iowa HHS review and approval. Iowa HHS will review all changes in tier resulting from a change in condition.
•For new assessments: Assign new enrollees to the tier assigned by the interRAI-ID or ChYMH-DD.
•For all assessments and reassessments: Support waiver enrollees to seek a review when they feel their needs cannot be met by the interRAI-ID or ChYMH-DD assigned tier.

Effective January 1, 2025, Member assignment to a tiered rate is defined as follows.
a.Acuity tiers are based on the results of the interRAI-Intellectual Disability (interRAI-ID for adults age 18+) and the Child and Youth Mental Health Developmental Disability (ChYMH-DD for children and youth below age 18).
b.The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the interRAI-ID and ChYMH-DD scores.
c.Scores are derived from items contained in the following sections:
o Section A. Identification Information
o Section B. Intake and Initial History
o Section C. Community and Social Involvement
o Section D. Strengths, Relationships, and Supports
o Section E. Lifestyle
o Section F. Environmental Assessment
o Section G. Communication and Vision
o Section H. Cognition
o Section I. Health Conditions

o Section N. Supports and Services
d.For adults over age 18, acuity tiers are the highest applicable tier pursuant to the following:
o Tier 1:
•Section H (Cognition) is zero (0) or one (1) and 18 or lower in Section N (Supports and Services) and a zero (0) or one (1) in Section A (Identification Information); OR
•Section H (Cognition) is two (2) or higher and Section F (Environmental Assessment) is zero (0) and Section D (Strengths, Relationships, and Supports) is 10 or higher and Section I (Health Conditions) is 16 or lower and
Section N (Supports and Services) is 11 or lower.
o Tier 2:
•Section H (Cognition) is zero (0) or one (1) and 19 or higher in Section N (Supports and Services); OR
•Section H (Cognition) is two (2) or higher and Section F (Environmental Assessment) is zero (0) and Section D (Strengths, Relationships, and Supports) is 10 or higher and Section I (Health Conditions) is 16 or lower and
Section N (Supports and Services) is 12 or higher.
o Tier 3:
•Section H (Cognition) is two (2) or higher and Section F (Environmental Assessment) is zero (0) and Section D (Strengths, Relationships, and Supports) is nine (9) or lower and Section A (Identification Information) is two
(2) or lower and Section I (Health Conditions) is 14 or higher.
o Tier 4:
•Section H (Cognition) is a score of two (2) or higher and Section F (Environmental Assessment) is zero (0) and Section D (Strengths, Relationships, and Supports) is nine (9) or lower and Section A (Identification
Information) is three (3) or higher and Section C (Community and Social Involvement) is 14 or higher; OR
•Section H (Cognition) is two (2) or higher and Section F (Environmental Assessment) is one (1) or higher and Section G (Communication and Vision) is one (1) or higher and Section E (Lifestyle) is four (4) or higher.
o Tier 5:
•Section H (Cognition) is between two (2) and eight (8) and Section F (Environmental Assessment) is one (1) or higher and Section G (Communication and Vision) is one (1) or higher and Section E (Lifestyle) is three (3) or
lower.
o Tier 6:
•Section H (Cognition) is zero (0) or one (1) and 18 or lower in Section N (Supports and Services) and a two (2) or higher in Section A (Identification Information); OR
•Section H (Cognition) is two (2) or higher and Section F (Environmental Assessment) is zero (0) and Section D (Strengths, Relationships, and Supports) is nine (9) or lower and Section A (Identification Information) is two
(2) or lower and Section I (Health Conditions) is 13 or lower; OR
•Section H (Cognition) is two (2) or higher and Section F (Environmental Assessment) is zero (0) and Section D (Strengths, Relationships, and Supports) is nine (9) or lower and Section A (Identification Information) is three
(3) or higher and Section C (Community and Social Involvement) is 13 or lower; OR
•Section H (Cognition) is two (2) or higher and Section F (Environmental Assessment) is zero (0) and Section D (Strengths, Relationships, and Supports) is 10 or higher and Section I (Health Conditions) is 17 or higher; OR
•Section H (Cognition) is 9 or higher and Section F (Environmental Assessment) is one (1) or higher and Section G (Communication and Vision) is one (1) or higher and Section E (Lifestyle) is three (3) or lower.
e. For children and youth under the age of 18 accessing residential based SCL, acuity tiers are the highest applicable tier pursuant to the scoring under (d) grouped as follows
o Tier 1 equals a score in adult tiers 1 or 2.
o Tier 2 equals a score in adult tiers 3 or 4.
o Tier 3 equals a score in adult tiers 5 or 6.
f. For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:
o Members who receive an average of 40 hours or more of day services per month.
o Members who receive an average of less than 40 hours of day services per month.
g. Tier redetermination. A member's acuity tier may be changed in the following circumstances:
o There is a change in the member's interRAI-ID or ChYMH-DD scores as determined in the annual level of care redetermination process.
o A completed DHS Form 470-5486, Emergency Needs Assessment, indicates a change in a member's support needs. A member's case manager may request an emergency needs assessment when a significant change in the member's needs is
identified. When a completed emergency needs assessment indicates significant changes that are likely to continue, a full interRAI-ID or ChYMH-DD assessment shall be conducted and any change in the scores will be used to
determine the member's acuity tier.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A Waiver Administration and Operation	
Appendix B Participant Access and Eligibility	6
Appendix C Participant Services	1
Appendix D Participant Centered Service Planning and Delivery	1. QI
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	1,2,QI
Appendix H	1
Appendix I Financial Accountability	2
Appendix J Cost-Neutrality Demonstration	

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

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other
Specify:

Change in assessment tool from Support Intensity Scale-Adult Version to the interRAI-Intellectual Disability and Support Intensity Scale-Children's Version to the Child and Youth Mental Health Developmental Disability. Also, change the participant survey being used from the IPES (Iowa Participant Experience Survey) to CAHPS (Consumer Assessment of Healthcare Providers and Systems) Home and Community-Based Services/Survey. By changing the survey tool being used two of the current performance measures also had to be re-written.

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

1. Request Information (1 of 3)

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

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

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

C. Type of Request: amendment

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

3 years **5 years**

Original Base Waiver Number: IA.0242
Draft ID: IA.011.07.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/24
Approved Effective Date of Waiver being Amended: 07/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

Hospital
Select applicable level of care

Hospital as defined in 42 CFR §440.10
If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160

Nursing Facility
Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155
If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)
If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

Not applicable

Applicable
Check the applicable authority or authorities:

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

Waiver(s) authorized under §1915(b) of the Act.
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

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

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

§1915(b)(2) (central broker)

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

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

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

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

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

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

A program authorized under §1115 of the Act.
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

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

Waiver Program Summary

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

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

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

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

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

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

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

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

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

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

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

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

4. Waiver(s) Requested

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

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

Not Applicable

No

Yes

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

No

Yes

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

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

Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make

participant-direction of services as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

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

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

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

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

1. Informed of any feasible alternatives under the waiver; and,

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

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

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

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

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on

the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and

improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the state secures public input into the development of the waiver:

HHS seeks continuous and ongoing public input through a variety of modalities, including townhalls, listening sessions, committees, and workgroups. Iowa Medicaid also participates and collaborates with a number of provider and member association and advocacy groups. Regular input into the operation and implementation of the waiver is obtained from Iowa Association of Community Providers, Iowa Coalition for Integration and Employment, Developmental Disabilities Council, Mental Health, and Disability Service (MHDS) Regions, Child Heath Specialty Clinics, Iowa State Association of Counties, Iowa Health Care Association, and Olmstead Task Force.

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

Iowa Medicaid used the following processes to secure public input into the development of the Intellectual Disabilities Waiver Renewal Application:

1) Iowa Medicaid Website Posting - https://hhs.iowa.gov/public-notice/2024-02-28/hcbs-id-waiver

2) HHS Field Office Posting – Iowa Medicaid provides notification to the HHS Field Office, which in turn, notifies each HHS Field Office to post the ID Waiver Public Notice and to provide a copy of the CMS Waiver Renewal Application for any public request.

3) Iowa Medicaid Public Notice Subscribers - Medicaid members, Medicaid providers, legislators, advocacy organizations and others who wish to remain informed regarding Iowa Medicaid can subscribe to the Iowa Medicaid Public Notice webpage. All subscribers will receive electronic notice whenever an update/public notice is posted. This process includes HCBS waiver renewals. The public posting period was the same for this process. The public notice period began on February 28, 2024 and closed on April 1, 2024. There were no public comments received during the notice period.

4) Iowa Tribal Nations Notification - The Tribal Nations were notified of the intent to renew the waiver via email February 29, 2024. The comment period remained open through April 1, 2024. The Tribal liaison for the department received no tribal comments during the notice period.

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

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

7. Contact Person(s)

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

Last Name: Watson

First Name: Brooke

Title: LTSS Program Policy Specialist

Agency: Iowa Department of Health and Human Services/Iowa Medicaid

Address: 1305 E. Walnut

Address 2:

City: Des Moines

State: Iowa

Zip: 50319

Phone: (515) 326-4887 **Ext:** **TTY**

Fax: (515) 725-1360

E-mail: bwatson2@dhs.state.ia.us

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

Last Name: Steenblock

First Name: Jennifer

Title: Federal Compliance Officer

Agency: Iowa Department of Health and Human Services/Iowa Medicaid

Address: 1305 E. Walnut

Address 2: Jsteenb@dhs.state.ia.us

City: Des Moines

State: Iowa

Zip:

50315-0114

Phone:

(515) 256-4636 **Ext:** **TTY**

Fax:

(515) 725-1360

E-mail:

Jsteenb@dhs.state.ia.us

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Iowa**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

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

Reducing the unduplicated count of participants (Factor C).

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

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Due to the character limitations in the application QP-a2 and SP-c1, and SP-e1 are listed below.

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.

Numerator: # Number of licensed/certified waiver provider re-enrollments verified against the appropriate licensing/certification standards prior to continuing to furnish services

Denominator: # of licensed/certified waiver provider re-enrollments.

SP-c1: Number and percent of CAHPS respondents who responded “YES” on the CAHPS survey to question 53 “In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?”.

Numerator: Number of CAHPS respondents who responded “YES” on the CAHPS survey to question 53 “In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?”.

Denominator: Total number of CAHPS respondents who were directed to question number 53 due to responding “YES” on the CAHPS survey to question 52 “In the last 3 months, did you ask this {case manager} for help in getting any changes to your services, such as more help from {personal assistance/behavioral health staff and/or homemakers if applicable}, or for help with getting places or finding a job?”.

SP-e1: Number and percent of CAHPS respondents who responded with either “MOST” or "ALL" on the CAHPS survey to question 56 “In the last 3 months, did your service plan include . . . of the things that are important to you”.

Numerator: Number of CAHPS respondents who responded with either “MOST” or "ALL" on the CAHPS survey to question 56 “In the last 3 months, did your service plan include . . . of the things that are important to you”.

Denominator: Total number of CAHPS respondents who responded to the CAHPS survey to question 56 “In the last 3 months, did your service plan include . . . of the things that are important to you”.

SCL Delivered Through Remote Support Additional Information:
-The use of remote supports and telehealth modalities for the delivery of SCL 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.

-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.

-The individual’s care coordinator or community-based case manager is responsible for monitoring the services in the person-centered service plan which includes at a minimum monthly contact with the individual or their representative and visiting individuals in their place of residence on a quarterly basis. The HCBS QIO and the MCOs also provide oversight of service delivery through the quality monitoring and oversight of the HCBS providers. Providers must have written policy and procedures approved by the Iowa Medicaid Quality Improvement Organization (QIO) HCBS unit that defines emergency situations and details. How remote and backup staff will respond to each. Examples include:
•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.
•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.
•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.

SCL Delivered through Telehealth Additional Information:

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.

“Telehealth” means the delivery of SCL 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.

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.

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

Bureau of Long-Term Services and Supports (LTSS), Iowa Medicaid

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

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

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

Member Services contractor disseminates information to Medicaid beneficiaries and provides support. Additionally, Member Services provides clinical review to identify beneficiary population risks such that additional education, program support, and policy revision can mitigate risks to the beneficiary when possible.

Medical Services Unit (MSU) contractor, part of the Quality Improvement Organization (QIO), conducts level of care evaluations and service plan development ad-hoc reviews to ensure that waiver requirements are met. In addition, QIO MSU conducts the necessary activities associated with prior authorization of waiver services, authorization of service plan changes and medical necessity reviews associated with Program Integrity and Provider Cost Audit activities.

HCBS Quality Improvement Organization (QIO) contractor reviews provider compliance with State and federal requirements, monitors complaints, monitors critical incident reports and technical assistance to ensure that quality services are provided to all Medicaid members.

Program Integrity and Recovery Audit Coordinator contractor reviews provider records and claims for instances of Medicaid fraud, waste, and abuse. These components are evaluated and analyzed at an individual and system level through fraud hotline referrals and algorithm development.

Provider Services contractor coordinates provider recruitment and executes the Medicaid Provider Agreement. The Provider Services Unit conducts provider background checks as required, conducts annual provider trainings, supervises the provider assistance call center, and manages the help functions associated with Iowa Medicaid's Institutional and Waiver Authorization and Narrative System (IoWANS)

Provider Cost Audit contractor determines service rates and payment amounts. The Provider Cost Audit Unit performs financial reviews of projected rates, reconciled cost reports, and performs onsite fiscal reviews of targeted provider groups.

Revenue Collections Unit contractor performs recovery of identified overpayments related to program integrity efforts, cost report reconciliations, third-party liability, and trusts.

Pharmacy contractor oversees the operation of the Preferred Drug List (PDL) and Prior Authorization (PA) for prescription drugs. The development and updating of the PDL allows the Medicaid program to optimize the funds spent for prescription drugs. The Pharmacy Medical group performs drug Prior Authorization with medical professionals who evaluate each request for the use of a number of drugs.

Point-of-Sale (POS) contractor is the pharmacy point of sale system. It is a real-time system for pharmacies to submit prescription drug claims for Iowa Medicaid beneficiaries and receive a timely determination regarding payment.

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

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

Appendix A: Waiver Administration and Operation

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

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Iowa Medicaid Medical Policy Staff, through HHS, is responsible for oversight of the contracted entities. Iowa Medicaid is the State Agency responsible for conducting the operational and administrative functions of the waiver.

Appendix A: Waiver Administration and Operation

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

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

All contracted entities are assigned a State-employed contract manager, are assessed through their performance-based contracts, and are required to report on their performance related to scope of work and deliverables. Monthly meetings are designed to facilitate communication among the various business units within Iowa Medicaid to ensure coordination of operations and performance outcomes. In addition, all contracted agencies are required to complete a comprehensive quarterly report on their performance to include programmatic and quality measures designed to measure the contract activities as well as trends identified within Medicaid programs and populations.

The State has established a Managed Care Bureau within Iowa Medicaid to provide comprehensive program oversight and compliance. Specifically, the Bureau Chief, reporting directly to the Medicaid Director, is responsible for directing the activities of bureau staff. Each MCO account manager will oversee contract compliance for one designated MCO. The MCO account managers will serve as liaisons between the MCOs and the State and will be the point of contact coordinating communications and connecting subject matter experts. The new Bureau will work directly with the Iowa Medicaid Program Integrity Unit, which oversees compliance of all Iowa Medicaid providers, including the MCOs.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care evaluation		
Review of Participant service plans		
Prior authorization of waiver services		
Utilization management		
Qualified provider enrollment		

Function	Medicaid Agency	Contracted Entity
Execution of Medicaid provider agreements		
Establishment of a statewide rate methodology		
Rules, policies, procedures and information development governing the waiver program		
Quality assurance and quality improvement activities		

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
AA-2: Number and percent of months in a calendar quarter that each MCO reported all HCBS PM data measures. Numerator = # of months each MCO entered all required HCBS PM data; Denominator = # of reportable HCBS PM months in a calendar quarter.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO performance monitoring

Responsible Party for data collection/generation*(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: MCOs	**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:
AA-1: Number and percent of required MCO HCBS PM quarterly reports that are submitted timely. Numerator = # of required MCO HCBS PM quarterly reports submitted timely; Denominator = # of MCO HCBS PM quarterly reports due in a calendar quarter.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO performance monitoring

Responsible Party for data collection/generation*(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: MCOs	**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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	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.

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify: Contracted Entity and MCOs	**Annually**
	Continuously and Ongoing

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	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 Administrative Authority that are currently non-operational.

No

Yes

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

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR ï¿½441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged			
		Disabled (Physical)			
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability	0		
Mental Illness					
		Mental Illness			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Serious Emotional Disturbance			

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

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

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

Not applicable. There is no maximum age limit

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	14780
Year 2	14780
Year 3	14780
Year 4	14780
Year 5	14780

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

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

Purpose(s) the state reserves capacity for:

Purposes	
Residential Based Supported Community Living	
Reserved Capacity slots (including MFP)	

Appendix B: Participant Access and Eligibility

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

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

Residential Based Supported Community Living

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Reserved Capacity slots (including MFP)

Purpose *(describe):*

The state will reserve 350 slots each year for use by participants living in an ICF/ID, nursing facility or out of state placement who choose to access services in the ID Waiver program. A reserved capacity slot is also available to members accessing the Money Follows the Person (MFP) grant as they transition from MFP funding to the ID waiver after one year of MFP funding. Slots are available for use by any eligible person for the ID waiver program that currently resides in an ICF/ID, nursing facility or out of state placement, has lived there for at least four months, and chooses the ID waiver program over institutional services.

Once the reserved capacity slot is accessed by a participant leaving an institution, the slot is not available to anyone else during the current waiver year. The ICF/ID reserved capacity slot will revert back into the pool of available ICF/ID reserved capacity slots at the end of the ID waiver year, ending June 30 each year. This will assure that no more than 350 slots are used in any given year and will assure that 350 slots are available annually. Once the applicant gets on the ID waiver, they are included in the annual participant count towards the total numbers served and unduplicated participant count identified in Appendix B-3 sections a. & b.

Describe how the amount of reserved capacity was determined:

The 350 slots were based on anticipated movement of consumers moving from ICF's/ID to community-based settings. This is consistent with the previous waiver year 5 approval.

The MFP grant allows members living within an ICF/ID to move to community-based services funded through the ID waiver. It is anticipated that each year of the MFP grant that 135 participants will move from facility-based settings to HCBS waiver programs. The MFP grant funds the first 365 days of services provided in the community. After the first year, the participant will apply for and receive funding through the ID waiver. The ICF/ID reserved capacity slots are intended to assure that participants living in ICF's/ID have slots available to make the transition to the community and continued funding through the ID waiver program after MFP funding ends.

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

Waiver Year	Capacity Reserved
Year 1	350

Waiver Year	Capacity Reserved
Year 2	350
Year 3	350
Year 4	350
Year 5	350

Appendix B: Participant Access and Eligibility

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

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

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

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

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

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

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

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

HHS assess applicants that submit the Waiver Priority Needs Assessment (WPNA) to determine the applicant's priority need.

Emergency Need: A person is considered to have an "emergency need" for enrollment in the HCBS Waiver if the health, safety or welfare of the person or others is in imminent danger and the situation cannot be resolved absent the provision of such services available from the HCBS waiver program. Without intervention institutionalization is imminent.

(1) Emergency need criteria are as follows:
1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.
2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.
3. The applicant is living in a homeless shelter, and no alternative housing options are available.
4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.
5. The applicant cannot meet basic health and safety needs without immediate supports. (Not applicable to children under age 18 due to parental responsibility)
6. There is reasonable belief that person is in imminent danger, or would be subject to abuse or neglect if the person does not receive immediate support or services.
7. The applicant is in crisis and institutionalization is imminent without supports in the next 30-60 days.
8. The caregiver is in extreme duress and can no longer provide for the applicants health and safety without supports in the next 30 to 60 days.

Urgent Need: A person is considered to have an "urgent need" for enrollment in the HCBS waiver if he or she is at significant risk of having his or her basic needs go unmet and waiver services are needed to avoid institutionalization.

(2) Urgent need criteria are as follows:
1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.
2. The caregiver will be unable to continue to provide care within the next 60 days.
3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.
4. The applicant is living in temporary housing and plans to move within 31 to 120 days. (Not applicable to CMH, PD and HD)
5. The applicant is losing permanent housing and plans to move within 31 to 120 days. (Not applicable to CMH, PD and HD)
6. The caregiver will be unable to be employed if services are not available.
7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.
8. The applicant has behaviors that put the applicant at risk.
9. The applicant has behaviors that put others at risk.
10. The applicant is at risk of facility placement when needs could be met through community-based services.

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

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

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

Applicants shall remain on the waiting list until a waiver slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list.
To maintain the approved number of members in the program, persons shall be selected from the waiting list as waiver slots become available, based on their priority order on the waiting list.

Once a waiver slot is assigned, the department shall give written notice to the person within five working days. The department shall hold the waiver slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

§1634 State

SSI Criteria State

209(b) State

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

No

Yes

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

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

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

SSI recipients

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

Optional state supplement recipients

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

Select one:

100% of the Federal poverty level (FPL)

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

Specify percentage:

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

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

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

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

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

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

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

Specify:

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

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

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

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

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

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).
Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

Use spousal post-eligibility rules under §1924 of the Act.
(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

income:

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(*select one*):

300% of the SSI Federal Benefit Rate (FBR)

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

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

HHS determines patient liability. Client participation is the amount that a member is required to contribute toward the cost of waiver services. To calculate client participation:
1.Determine only the member's total gross monthly income.
2.Subtract a maintenance needs allowance of 300% of the current SSI benefit for one person.
3.For participants who have a medical assistance income trust (Miller Trust) subtract:
a.an additional $10 for trustee fee
b. A deduction for spouse and/or dependent needs
4.Add in veteran's aid and attendance, house-bound allowance, or other third-party payments not counted as income for eligibility.
The result is the client participation amount.

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

Not Applicable

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

Specify:

Specify the amount of the allowance (*select one*):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (*select one*):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage: [ ]

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

[ ]

Other

Specify:

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

HHS determines patient liability. Client participation is the amount that a member is required to contribute toward the cost of waiver services. To calculate client participation:
1. Determine only the member’s total gross monthly income.
2. Subtract a maintenance needs allowance of 300% of the current SSI benefit for one person.
3. Add in veteran’s aid and attendance and veteran’s housebound allowance.
The result is the client participation amount.
4. The IMW makes client participation entries on the Automated Benefit Calculation (ABC) system. The IMW notifies the HCBS case manager of the type and amount of client participation to be paid, if any. It is a HCBS case manager’s responsibility to apply the client participation toward a specific service.
For managed care enrollees with a patient liability, HHS will communicate to the MCO the amount of each member's liability. Members will be responsible for remitting their patient liability to their waiver providers. The MCO reduces its payment for a member's waiver services up to the amount of the patient liability.

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

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

Select one:

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

The state does not establish reasonable limits.

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

The provision of waiver services at least monthly

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

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

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

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

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

Medical professionals (i.e., licensed physician, physician assistant or advanced registered nurse practitioner) perform the initial evaluation/completion of the assessment tool. Iowa Medicaid requires that professionals completing the level of care determination are licensed RNs. If the RN is unable to approve level of care, then the Physician Assistant or MD make the final level of care determination.

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

All criteria outlined in this section apply to both initial and reevaluation of Level of Care.

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

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

Ages 0-4 Case Management Comprehensive Functional Assessment Tool (Form 470-4694)
Ages 5-15 interRAI Child and Youth Mental Health Instrument for Developmental Disabilities (ChYMH-DD)
Ages 16+ interRAI Intellectual Disability (interRAI-ID)

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

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

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

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

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

The interRAI Intellectual Disability (interRAI-ID) and the interRAI Child and Youth Mental Health Instrument for Developmental Disabilities (ChYMH-DD) is used to assess participants age 5 and above accessing the ID waiver and ICF/ID facility placement. The interRAI-ID and ChYMH-DD are user-friendly, reliable, person-centered assessment tools that inform and guide comprehensive care and person-centered service planning in community-based settings around the world. interRAI focuses on the person's functioning and quality of life by assessing needs, strengths, and preferences, and facilitates referrals when appropriate. When used over time, it provides the basis for an outcome-based assessment of the person's response to care or services.

The interRAI-ID must be completed for each participant in the ID waiver and ICF/ID once in a three-year time period. During the two "off" years, an off year assessment tool is utilized for annual level of care redeterminations for adults. The off year assessment reviews and identifies if any significant changes have occurred that would change the results and findings of the current interRAI-ID assessment. If there is significant change, a new interRAI-ID is administered.

For children under age 5, the Case Management Comprehensive Functional Assessment Tool Form 470-4694 is used each year. Additional or supplemental information is submitted with the members residing in the ICF/ID. If additional information is needed to determine LOC in either HCBS or ICF/ID, the Review Coordinator will request additional information to assure the functional criteria is met for the ICF/ID LOC.

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

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

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

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

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

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

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

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

Every three months

Every six months

Every twelve months

Other schedule
Specify the other schedule:

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

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

The qualifications are different.
Specify the qualifications:

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

FFS
The Iowa Medicaid CSA contractor is responsible for submitting timely level of care reevaluations of members. Reevaluations are considered timely if they are completed within twelve (12) months of the previous evaluation. Reevaluations of FFS members are tracked in the HHS Institutional and Waiver Authorization and Narrative System (IoWANS). An IoWANS milestone is sent out to the FFS CSA contractor 60 days before the reevaluation is due.

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

A CSR or re-evaluation report is also available through IoWANS to track overdue reevaluations and is monitored by Medical Services, the Bureau of LTSS, and Iowa Medicaid.

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

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
LC-a1: Number and percent of referrals for LOC that received a completed LOC decision. Numerator: # of referrals for LOC that received a completed LOC decision; Denominator: # of referrals for LOC.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FFS and MCO members will be pulled from IoWANS for this measure. Iowa Medicaid MSU completes all initial level of care determinations for both FFS and MCO populations.

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 levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
LC-c1: Number and percent of initial level of care decisions that were accurately determined by applying the approved LOC criterion using standard operating procedures. Numerator: # of initial LOC decisions that were accurately determined by applying the approved LOC criterion using standard operating procedures; Denominator: # of reviewed initial LOC determinations

Data Source (Select one):
Other
If 'Other' is selected, specify:
IME MQUIDS and OnBase

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 =

		95% confidence level with +/- 5% margin of error
Other Specify: Contracted entity	**Annually**	**Stratified** Describe Group: IA.0299 - BI (6%) IA.0213-AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	Continuously and Ongoing	**Other** Specify:
	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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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.

Data for completed LOC is collected quarterly through reports generated through IoWANS, MQUIDS, and OnBase. This data is monitored for trends from an individual and systems perspective to determine in procedural standards.

Monthly a random sample of LOC decisions is selected from each reviewer. Internal quality control activity is completed on the random sample. This level of scrutiny aids in early detection of variance from the stated LOC criteria.

b. Methods for Remediation/Fixing Individual Problems

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

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

When an eligibility approval is made in error, the State allows for timely notice and discontinues the participant's benefits. All payments that were made for services, in which the participant was not actually eligible for, are deemed as an error and an overpayment is set to be collected from the participant. The eligibility worker reaches out to the participant at that time, explains to them what happened and encourages them to not use any additional services that will need to be repaid. If the participant is only eligible due to being eligible for the waiver, all Medicaid and waiver payments will be subject to the overpayment. If the participant is eligible for Medicaid on their own right, then only the waiver services are subject to the overpayment recoupment.

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:	**Annually**

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	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 Level of Care that are currently non-operational.

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

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

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

MCO
MCO community case managers are required to ensure that members are offered choice according to their respective MCO processes and forms, which are reviewed and approved by HHS. The MCOs provide oversight of service planning by reviewing the person-centered service plan to determine if choice between waiver and institutional care has been provided and provider choice is offered.

In addition, Iowa Medicaid QIO reviews the person-centered service plan to determine if provider choice is offered.

The HCBS QIO Unit will review person centered service plans to ensure members were offered a choice of HCBS providers

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

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

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

MCO

MCOs are responsible for maintaining records that fully disclose the extent of services provided to members for a minimum of seven years and must furnish such information to duly authorized and identified agents or representatives of the state and federal governments. The MCOs maintain copies of freedom of choice forms in the MCO database and the member’s electronic health record.

Appendix B: Participant Access and Eligibility

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

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

Iowa HHS adopts the policy as set forth in Title VI of the Civil Rights Act prohibiting national origin discrimination as it affects people with limited English proficiency. HHS shall provide for communication with people with limited English proficiency, including current and prospective patients or clients, family members and members to ensure them an equal opportunity to benefit from services. HHS has developed policies and procedures to ensure meaningful access for people with limited English proficiency. This includes procedures to:
- Identify the points of contact where language assistance is needed.
- Identify translation and interpretation resources, including their location and their availability.
- Arrange to have these resources available in timely manner.
- Determine the written materials and vital documents to be translated, based on the populations with limited English proficiency and ensure their transition.
- Determine effective means for notifying people with limited English proficiency of available translation services available at no cost.
- Train department staff on limited English proficiency requirements and ensure their ability to carry them out.
- Monitor the application of these policies on at least an annual basis to ensure ongoing meaningful access to services.

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

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

-MCOs must conform to HHS policies regarding meaningful access to the waiver by limited English proficient persons, and to deliver culturally competent services in accordance with 42 CFR 438.206.
- MCOs must provide language services at no cost to limited English proficiency members, and all written materials shall be provided in English and Spanish, as well as any additional prevalent languages identified by the State or through an analysis of member enrollment (i.e., any language spoken by at least five percent (5%) of the general population in the MCO’s service area).
- MCOs must provide oral interpretation services free of charge to each member (this applies to all non-English languages, and is not limited to prevalent languages), and MCOs must notify all members that oral interpretation and translated written information is available and how to access those services. Written materials must include taglines in prevalent languages regarding how to access materials in alternative languages.
- MCOs must ensure that service plans reflect cultural considerations of the member and that service plan development is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b).
- MCOs must operate member services helplines that are available to all callers, and an automated telephone menu options must be made available in English and Spanish.
- MCOs must maintain member websites and mobile applications available in English and Spanish that are accessible and functional via cell phone.

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope)*:

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

Adult day care services provide an organized program of supportive care in a group 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 when transportation is provided to and from the ADC location the cost of transportation is included in the rate paid to the ADC provider.

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 if the cost of transportation is provided and charged to Medicaid, the cost of transportation must be included in the adult day health rate.

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	Supported Community Living Providers Certified under the BI or ID Waivers
Agency	Respite Providers Certified Under the BI or ID Waivers
Agency	Home Health Agency Certified to Provide Respite
Individual	Home Care Agency Certified to Provide Respite
Agency	Adult Day Care Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Supported Community Living Providers Certified under the BI or ID Waivers

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: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Respite 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:

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:

Individual

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:

Adult Day Care Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.
Components of this service include the following:
Day Habilitation means services that provide opportunities and support for community inclusion and build interest in and develop skills for active participation in recreation, volunteerism and integrated community employment. Day habilitation provides assistance with acquisition, retention, or improvement of socialization, community participation, and daily living skills.
Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or the member's individual goals as identified in the member's comprehensive service plan. Services may also provide wraparound support secondary to community employment.
Day habilitation activities may include:
(1) Identifying the member's interests, preferences, skills, strengths and contributions,
(2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,
(3) Planning and coordination of the member's individualized daily and weekly day habilitation schedule,
(4) Developing skills and competencies necessary to pursue competitive integrated employment
(5) Participating in community activities related to hobbies, leisure, personal health, and wellness,
(6) Participating in community activities related to cultural, civic, and religious interests,
(7) Participating in adult learning opportunities,
(8) Participating in volunteer opportunities,
(9) Training and education in self-advocacy and self-determination to support the member's ability to make informed choices about where to live, work, and recreate,
(10) Assistance with behavior management and self-regulation,
(11) Use of transportation and other community resources,
(12) Assistance with developing and maintaining natural relationships in the community,
(13) Assistance with identifying and using natural supports,
(14) Assistance with accessing financial literacy and benefits education,
(15) Other day habilitation activities deemed necessary to assist the member with full participation in the community.

Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes.
Expected outcome of service. The expected outcome of day habilitation services is active participation in the community in which the member lives, works, and recreates. Members are expected to have opportunities to interact with individuals without disabilities in the community, other than those providing direct services, to the same extent as individuals without disabilities.

Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member's residence. Family training may be provided in the member's home.

Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

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

Transportation. When transportation is provided to the day habilitation service location from the member's home and from the day habilitation service location to the member's home, the day habilitation provider may bill for the time spent transporting the member.

A unit of service may be a 15- minute unit or a full day (4.25 to 8 hours). For the family training option, a unit of service is a 15 minute unit

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

Exclusions. Day habilitation payment shall not be made for the following:
(1) Vocational or prevocational services. 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 day habilitation services.
(2) Compensation to members for participating in day habilitation services.
(3) Support for members volunteering in for-profit organizations and businesses.
(4) Support for members volunteering to benefit the day habilitation service 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.

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

Exclusions. Day habilitation payment shall not be made for the following:
(1) Vocational or prevocational services. 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 day habilitation services.
(2) Compensation to members for participating in day habilitation services.
(3) Support for members volunteering in for-profit organizations and businesses.
(4) Support for members volunteering to benefit the day habilitation service 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:

The units of family training option services are limited to a maximum of 40, 15-minute units per month. If additional family training service units are needed, an exception to policy (ETP) may be requested by the member, case manager or community based case manager. An ETP requires the Department to review and prior authorization any additional services above the 40 units. .

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	Joint Commission on Accreditation of Healthcare accredited
Agency	CARF Accredited
Agency	CQL Accredited

Provider Category	Provider Type Title
Agency	International Center for Clubhouse Development Accredited

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Joint Commission on Accreditation of Healthcare accredited

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers accredited by the Joint Commission on Accreditation of Healthcare to provide services that qualify as day habilitation pursuant to Iowa Administrative Code 441- 78.27(8)

Direct support staff providing day habilitation 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 degree. 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 adoption of this rule, complete at least 9.5 hours of training in supporting members in the activities listed in the service description as offered through DirectCourse or Relias or other nationally recognized training curriculum.

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: Day Habilitation

Provider Category:

Agency

Provider Type:

CARF Accredited

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation pursuant to Iowa Administrative Code 441- 78.27(8)

Direct support staff providing day habilitation 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 degree. 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 adoption of this rule, complete at least 9.5 hours of training in supporting members in the activities listed in the service description as offered through DirectCourse or Relias or other nationally recognized training.
4) A person providing direct support shall annually complete 4 hours of continuing education in supporting members in the activities listed in paragraph 78.27(8)“a,” as offered through DirectCourse or Relias or other nationally recognized training curriculum.

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: Day Habilitation

Provider Category:

Agency

Provider Type:

CQL Accredited

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies accredited by the Council on Quality and Leadership to provide services that qualify as day habilitation pursuant to Iowa Administrative Code 441- 78.27(8).

Direct support staff providing day habilitation 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 degree. 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 adoption of this rule, complete at least 9.5 hours of training in supporting members in the activities listed in the service description as offered through DirectCourse or Relias or other nationally recognized training.
4) A person providing direct support shall annually complete 4 hours of continuing education in supporting members in the activities listed in paragraph 78.27(8)"a," as offered through DirectCourse or Relias or other nationally recognized training curriculum.

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: Day Habilitation

Provider Category:

Agency

Provider Type:

International Center for Clubhouse Development Accredited

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers accredited by the International Center for Clubhouse Development to provide services that qualify as day habilitation pursuant to Iowa Administrative Code 441- 78.27(8)

Direct support staff providing day habilitation 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 degree. 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 adoption of this rule, complete at least 9.5 hours of training in supporting members in the activities listed in the service description as offered through DirectCourse or Relias or other nationally recognized training curriculum.

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:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

Service Definition *(Scope)*:

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

"Prevocational services" means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.
Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.
Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.
(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially based informed choice regarding the goal of individual employment. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include but is not limited to the following activities:
1. Meeting with the member, and their family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences
2. business tours,
3. informational interviews,
4. job shadows,
5. benefits education and financial literacy,
6. assistive technology assessment, and
7. other job exploration events.
(2) Expected outcome of service.
1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
2.The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.
b. Setting. Prevocational services shall take place in community-based nonresidential settings.
c. Concurrent services. A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

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

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 hour.

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

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian
Provider Specifications:

Provider Category	Provider Type Title
Agency	CARF Accredited
Agency	CQL Accredited

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:

CARF Accredited

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

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

Verification of Provider Qualifications
Entity Responsible for Verification:

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: Prevocational Services

Provider Category:

Agency

Provider Type:

CQL Accredited

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers accredited by the Council on Quality and Leadership.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Based Supported Community Living

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.
a. Allowable service components are the following:
(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.
(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.
(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and
that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.
4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child,
including interventions to ameliorate problem behaviors.
b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.
c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid. The services under the Intellectual Disability Waiver, including the RBSCL service, are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with the waiver objectives of avoiding institutionalization. The member's case manager is responsible for assuring state plan services, including EPSDT, are appropriately authorized in the member's services plan as needed.d. Room and board costs are not reimbursable as residential-based supported community living services.
e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)"d."
f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program

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

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

The services under the Intellectual Disabilities Waiver. including RBSCL 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	Foster care
Agency	RCF/ID
Agency	Certified Supported Community Living Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Based Supported Community Living

Provider Category:

Agency

Provider Type:

Foster care

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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: Residential Based Supported Community Living

Provider Category:

Agency

Provider Type:

RCF/ID

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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: Residential Based Supported Community Living

Provider Category:

Agency

Provider Type:

Certified Supported Community Living Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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:

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Agency	Camps
Agency	Facility- Nursing Facility
Agency	Home Care Agency
Agency	Childcare Facility
Agency	Facility- ICF/ID
Agency	Home Health Agency
Agency	Facility- Hospital
Agency	Group Living Foster Care Facility
Agency	Facility- Residential Care Facility
Agency	Assisted Living Programs
Agency	Adult Day Care

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:

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- Nursing Facility

Provider Qualifications

License *(specify):*

Licensed by the Department of Inspections and Appeals 481 IAC Chapters 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 provider services unit.
c. 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 Iowa Medicaid provider services unit.
e. 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.
(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:

Home Care Agency

Provider Qualifications

License *(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.

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 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:

Childcare Facility

Provider Qualifications

License *(specify):*

Childcare Facilities that are defined as childcare 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:

Facility- ICF/ID

Provider Qualifications

License *(specify):*

Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) licensed 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 Agency

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: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Facility- Hospital

Provider Qualifications

License *(specify):*

Licensed 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:

Group Living Foster Care Facility

Provider Qualifications

License *(specify):*

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

Facility- Residential Care Facility

Provider Qualifications

License *(specify):*

RCF licensed 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:

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 department of 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: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

Service Definition *(Scope):*

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

Individual supported employment (SE) 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.

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.

Individual SE services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.
Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:
1.Benefits education
2.Career exploration (e.g., tours, informational interviews, job shadows).
3.Employment assessment.
4.Assistive technology assessment.
5.Trial work experience.
6.Person-centered employment planning.
7.Development of visual/traditional résumés.
8.Job-seeking skills training and support.
9.Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10.Job analysis (e.g., work site assessment or job accommodations evaluation).
11.Identifying and arranging transportation.
12.Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13.Re-employment services (if necessary due to job loss).
14.Financial literacy and asset development.
15.Other employment support services deemed necessary to enable the member to obtain employment.
16.Systematic instruction and support during initial on-the-job training including initial on the job training to stabilization.
17.Engagement of natural supports during initial period of employment.
18.Implementation of assistive technology solutions during initial period of employment.
19.Transportation of the member during service hours.

Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home- based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed assistance to establish self-employment may include:
1.Aid to the member in identifying potential business opportunities.
2.Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3.Identification of the long-term supports necessary for the individual to operate the business.

Long-term job coaching 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.

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

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

Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized and service plan are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:
1.Job analysis.
2.Job training and systematic instruction.
3.Training and support for use of assistive technology/adaptive aids.
4.Engagement of natural supports.
5.Transportation coordination.
6.Job retention training and support.
7.Benefits education and ongoing support.
8.Supports for career advancement.
9.Financial literacy and asset development.
10.Employer consultation and support.
11.Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
12.Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
13.Transportation of the member during service hours.
14.Career exploration services leading to increased hours or career advancement.

Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10)"b"(4), assistance to maintain self-employment may include:
1.Ongoing identification of the supports necessary for the individual to operate the business;
2.Ongoing assistance, counseling and guidance to maintain and grow the business; and
3.Ongoing benefits education and support.

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

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

Small-group SE 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 SE services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group SE services is not a prerequisite for individual SE 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 SE services shall take place in integrated, community-based nonresidential settings separate from the member's residence.

Service activities. Small-group SE 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 SE 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.
•In-person contact is not required as a prerequisite for payment."

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.

"Telehealth" means the delivery of SE 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.

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.

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 for Individual Supported Employment is 15 minutes
A unit of service for Small group Employment is 15 minutes
A unit of service for Long-Term Job Coaching is a monthly unit of service. The hours of support tier assignment for long-term job coaching is based on the identified needs of the member as documented in the member's comprehensive service plan and adjusted when higher support needs are determined based on the hours of support the member requires each month.

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

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

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:

CAFC Accredited

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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 Accredited

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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 Accredited

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

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

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
(3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

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 Accredited

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

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

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
(3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

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:

Joint Accredited

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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:

Home Health Aide Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

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

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

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

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

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:

Services shall include unskilled medical services and shall exceed those services provided under HCBS ID waiver supported community living or the Medicaid state plan home health aide benefit. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.
a. Services shall be included in the consumer's individual comprehensive plan.
b. A unit is one hour.
c. A maximum of 14 units are available per week. If additional home health aide service is needed, a request for an exception to policy may be submitted to the Department for review.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Home Health Aide Services

Provider Category:
Agency
Provider Type:

Home Health Agencies

Provider Qualifications
License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications
Entity Responsible for Verification:

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:

Nursing

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Nursing

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

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

Other Standard *(specify)*:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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:

Financial Management Services

Alternate Service Title (if any):

Financial Management Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Institution

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Financial Institution

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

As defined in IAC 441 Chapter 77.30(13), the financial institution shall either:
(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or
(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).
b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.
c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.
d. The financial institution shall enroll as a Medicaid provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

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:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

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

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Support Broker

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Independent Support Broker

Provider Category:
Individual
Provider Type:

Individual Support Broker
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications
Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 an 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
Agency	Individual Directed Goods and Services
Individual	Individual Directed Goods and Services

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Individual Directed Goods and Services

Provider Category:
Agency
Provider Type:

Individual Directed Goods and Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

All personnel providing self-directed community supports and employment shall:
(1) Be at least 18 years of age.
(2) Be able to communicate successfully with the member.
(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
(5) Not be the parent or stepparent of a minor child member or the spouse of a member.
d. The provider of individual-directed goods and services shall:
(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
(2) Submit invoices and time sheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and time sheets are received after this 30-day period.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Individual Directed Goods and Services

Provider Category:

Individual

Provider Type:

Individual Directed Goods and Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.
a. A business providing individual-directed goods and services shall:
(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
(2) Have current liability and workers' compensation coverage.
b. An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.
c. All personnel providing individual-directed goods and services shall:
(1) Be at least 18 years of age.
(2) Be able to communicate successfully with the member.
(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
(5) Not be the parent or stepparent of a minor child member or the spouse of a member.
d. The provider of individual-directed goods and services shall:
(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Self Directed Community Support and Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope)*:

Category 4:	Sub-Category 4:

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

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

The following are examples of supports a member can purchase to help the member live and work in the community:
o Career counseling
o Career preparation skills development
o Cleaning skills development
o Cooking skills development
o Grooming skills development
o Job hunting and career placement
o Personal and home skills development
o Safety and emergency preparedness skills development
o Self-direction and self-advocacy skills development
o Social skills development training
o Supports to attend social activities
o Supports to maintain a job
o Time and money management
o Training on use of medical equipment
o Utilization of public transportation skills development
o Work place personal assistance

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

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:

Community support and employment services must be identified on the individual budget plan. The individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget. The ID waiver allows for the following eight ID waiver services to be converted to create a CCO budget:
1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business
Individual	Individual

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Self Directed Community Support and Employment

Provider Category:

Agency

Provider Type:

Business

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

All personnel providing self-directed community supports and employment shall:
(1) Be at least 18 years of age.
(2) Be able to communicate successfully with the member.
(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
(5) Not be the parent or stepparent of a minor child member or the spouse of a member.
d. The provider of individual-directed goods and services shall:
(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
(2) Submit invoices and time sheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and time sheets are received after this 30-day period.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Self Directed Community Support and Employment

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

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

All personnel providing self-directed community supports and employment shall:
(1) Be at least 18 years of age.
(2) Be able to communicate successfully with the member.
(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
(5) Not be the parent or stepparent of a minor child member or the spouse of a member.
d. The provider of individual-directed goods and services shall:
(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
(2) Submit invoices and time sheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and time sheets are received after this 30-day period.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Self Directed Personal Care

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

Service Definition *(Scope):*

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

Self-directed personal care services are services and/or goods that provide a range of assistance in the member's home or community that they would normally do themselves if they did not have a disability; activities of daily living and incidental activities of daily living that help the person remaining the home and in their community. This assistance may take the form of hands-on assistance (actually performing a task for a person) or cuing to prompt the participant to perform a task. Personal care may be provided on an episodic or on a continuing basis.

The member will have budget authority over self-directed personal care services. The dollar amount available for this service will be based on the needs identified on the service plan. Overlapping of services is avoided by the use of a case manager who manages all services and the entry into the IoWANS system. The case manager and interdisciplinary team determine which service is necessary and authorize transportation for both HCBS and self-directed services.

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

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. The individual budget limit will be based on the service plan and the need for the services available to be converted. A utilization adjustment rate will be applied to the individual budget amount. Transportation costs within this service is billed separately and not included in the scope of personal care. Please see Section E-2- b ii. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Business

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Self Directed Personal Care

Provider Category:
Individual
Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

All personnel providing self-directed community supports and employment shall:
(1) Be at least 18 years of age.
(2) Be able to communicate successfully with the member.
(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
(5) Not be the parent or stepparent of a minor child member or the spouse of a member.
d. The provider of individual-directed goods and services shall:
(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
(2) Submit invoices and time sheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and time sheets are received after this 30-day period.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Self Directed Personal Care

Provider Category:

Agency

Provider Type:

Business

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

All personnel providing self-directed community supports and employment shall:
(1) Be at least 18 years of age.
(2) Be able to communicate successfully with the member.
(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
(5) Not be the parent or stepparent of a minor child member or the spouse of a member.
d. The provider of individual-directed goods and services shall:
(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
(2) Submit invoices and time sheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and time sheets are received after this 30-day period.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Attendant Care (CDAC) - skilled

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope)*:

Category 4:

Sub-Category 4:

Consumer Directed Attendant Care skilled activities may include helping the member with any of the following skilled services while under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. This service may be provided in the private residence or assisted living. Skilled CDAC is not skilled nursing care, but is care provided by a lay person who has been trained to provide the specific service needed by the member.

The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The nurse is responsible for overseeing the care of the Medicaid member but is not the service provider. The cost of the supervision provided under state plan funding and is not provided under the waiver.

Skilled CDAC service is not duplicative of HHA or nursing. The case manager through the service plan authorization specifies the services and providers to provide waiver services and precludes duplication of services.

Covered skilled service activities:
(1) Tube feedings of members unable to eat solid foods.
(2) Intravenous therapy administered by a registered nurse.
(3) Parenteral injections required more than once a week.
(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, re-motivation,and behavior modification.
(8) Colostomy care.
(9) Care of out of control medical conditions which includes brittle diabetes, and comfort care of terminal conditions.
(10) Post-surgical nursing care.
(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
(12) Preparing and monitoring response to therapeutic diets.
(13) Recording and reporting of changes in vital signs to the nurse or therapist.

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 15 - minute unit provided by an individual or an agency. The member's plan of care will address how the member's health care needs are being met. The case manager will monitor the plan.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Action Agency

Provider Category	Provider Type Title
Agency	Community Business
Individual	Any individual who contracts with the member
Agency	Home Care Provider
Agency	Supported Community Living Providers
Agency	Home Health Agency
Agency	AAA subtracting Chore Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) - skilled

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Community action agencies as designated in Iowa Code section 216A.93. 216A.92 Division of community action agencies.

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 action 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:

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 (CDAC) - 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 (CDAC) - skilled

Provider Category:

Individual

Provider Type:

Any individual who contracts with the member

Provider Qualifications

License *(specify)*:

Certificate *(specify):*

Other Standard *(specify):*

An individual who contracts with the member to provide attendant care service and who is:
1. At least 18 years of age, and
2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.
3. Not the 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. 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: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) - skilled

Provider Category:

Agency

Provider Type:

Home Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in Iowa Administrative Code 641-80.5(135), 641-80.6(135), and 641-80.7(135).

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 Home Care Provider 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:

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 (CDAC) - skilled

Provider Category:

Agency

Provider Type:

Supported Community Living Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers certified by the Department's Home and Community Based Services Quality Oversight Unit to provide Supported Community Living under the Intellectual Disability or Brain Injury Waiver as described in IAC 441 Chapters 77.37 and 77.39.

Other Standard *(specify):*

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 SCL provider 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:

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 (CDAC) - skilled

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify)*:

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

Other Standard *(specify)*:

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 Home Health 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:

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 (CDAC) - skilled

Provider Category:

Agency

Provider Type:

AAA subtracting Chore Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

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:

Category 2:

Sub-Category 2:

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

Service Definition *(Scope):*

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

Consumer-directed attendant care (CDAC) services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. This service may be provided in the private residence. This service is not duplicative of Home Health Aide and is monitored by the case manager as part of inclusion in the member's plan. CDAC is not duplicative of self-directed personal care services. CDAC–unskilled is one of eight ID waiver services that may be used to create a self-directed budget amount CCO. When CDAC is authorized in the CCO budget, the case manager is responsible to assure that the service needs are being met and there is no duplication of services.

The service activities may include helping the member with any of the following non-skilled service activities:

1) Dressing.
2) Bath, shampoo, hygiene, and grooming.
3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
4) Toilet assistance, including bowel, bladder, and catheter assistance.
5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.
6) Housekeeping services which are essential to the member’s health care at home, includes shopping and laundry.
7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider.
8) Wound care.
9) Assistance needed to go to or return from a place of employment and assistance with job related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in member directed attendant care services.
10) Tasks such as financial management and scheduling that require cognitive or physical assistance.
11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devises for communication.
(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

Self-directed services allows a member to manage and direct services to meet their assessed needs. The needs are identified through the authorization of a waiver service. The authorized service is converted to a monthly budget. The budget is used to purchase optional services through the CCO program. CCO services do not duplicate waiver services, but rather are designed to meet the needs of the authorized service. They are provided to meet the same need, but with CCO the service is called self-directed personal care and not CDAC - unskilled.

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. The member's plan of care will address how the member's health care needs are being met. The case manager will monitor the plan.

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

CDAC services, unskilled, may be authorize in a member's service plan in conjunction with other self-direction services but must not be duplicative of the amount, duration, and scope of authorized personal care services in the service plan.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Any individual who contracts with the member
Agency	Supported Community Living Providers
Agency	Home Health Agency
Agency	Assisted Living Programs
Agency	Community Action Agency
Agency	Home Care Providers
Agency	Adult Day Care
Agency	AAA subtracting Chore Providers
Agency	Community Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) - unskilled

Provider Category:

Individual

Provider Type:

Any individual who contracts with the member

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An individual who contracts with the member to provide attendant care service and who is:
1. At least 18 years of age, and
2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.
3. Not the 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. 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: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) - unskilled

Provider Category:
Agency

Provider Type:

Supported Community Living Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers certified by the Department's Home and Community Based Services Quality Oversight Unit to provide Supported Community Living under the Intellectual Disability or Brain Injury Waiver as described in IAC 441 Chapters 77.37 and 77.39.

Verification of Provider Qualifications

Entity Responsible for Verification:

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 (CDAC) - unskilled

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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 Home Health 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:

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 (CDAC) - unskilled

Provider Category:

Agency

Provider Type:

Assisted Living Programs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Assisted living programs that are certified by the Department of Inspections and Appeals under 481—Chapter 69.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Other Standard *(specify):*

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 ALP 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:

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 (CDAC) - unskilled

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Community action agencies as designated in Iowa Code section 216A.93. 216A.92 Division of community action agencies.

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 action 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:

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 (CDAC) - unskilled

Provider Category:

Agency

Provider Type:

Home Care Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in Iowa Administrative Code 641-80.5(135), 641-80.6(135), and 641-80.7(135).

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 Home Care 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:

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 (CDAC) - unskilled

Provider Category:

Agency

Provider Type:

Adult Day Care

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

Other Standard *(specify):*

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 adult day care 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:

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 (CDAC) - unskilled

Provider Category:
Agency

Provider Type:

AAA subtracting Chore Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements.

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 chore 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:

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

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

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, 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: 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, 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: 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, 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: 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, 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	Sub-Category
Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.
a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle modifications are not furnished to adapt living arrangements that are owned or leased by providers of waiver services. Modifications may be made to privately owned rental properties. Home and vehicle repairs are also excluded. Purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle is not allowable.
b. Only the following modifications are covered:
(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
(3) Grab bars and handrails.
(4) Turnaround space adaptations.
(5) Ramps, lifts, and door, hall and window widening.
(6) Fire safety alarm equipment specific for disability.
(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
(9) Keyless entry systems.
(10) Automatic opening device for home or vehicle door.
(11) Special door and window locks.
(12) Specialized doorknobs and handles.
(13) Plexiglas replacement for glass windows.
(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
(15) Motion detectors.
(16) Low-pile carpeting or slip-resistant flooring.
(17) Telecommunications device for the deaf.
(18) Exterior hard-surface pathways.
(19) New door opening.
(20) Pocket doors.
(21) Installation or relocation of controls, outlets, switches.
(22) Air conditioning and air filtering if medically necessary.
(23) Heightening of existing garage door opening to accommodate modified van.
(24) Bath chairs.

All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes. Services shall be performed following prior department approval of the modification as specified in 441 - sub-rule 79.1(17) and a binding contract between the provider and the member. All contracts for home or vehicle modification shall be awarded through competitive bidding.

Home modifications will not be furnished to adapt living arrangements that are owned or leased by providers of waiver services including an assisted living facility.

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 the completion of needed modifications or adaptations. HVM within the ID waiver is limited to a $5,305.53 lifetime maximum. The member's plan of care will address how the member's health care needs are being met by the modification. Services must be authorized in the service plan by the case manager. Members may request an exception to policy to exceed the annual lifetime home and vehicle modification amount. The department reviews and prior authorizes all HVM requests, including requests to exceed the lifetime maximum. A notice of decision is issued to the member with all prior authorization reviews.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Business
Agency	Supported Community Living Providers
Agency	HVM Providers Enrolled under Other Waivers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home and Vehicle Modification

Provider Category:

Agency

Provider Type:

Community Business

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Submit verification of current liability and workers compensation coverage.

Verification of Provider Qualifications

Entity Responsible for Verification:

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:

Supported Community Living Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers certified by the Department's Home and Community Based Services Quality Oversight Unit to provide Supported Community Living under the Intellectual Disability or Brain Injury Waiver as described in IAC 441 Chapters 77.37 and 77.39.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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:

HVM Providers Enrolled under Other Waivers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers enrolled to participate as HVM providers under the Health and Disability Waiver (formerly the Ill and Handicapped waiver) as described in IAC 441 Chapter 30:
a.Area agencies on aging as designated in 17—4.4(231).
b.Community action agencies as designated in Iowa Code section 216A.93.
c.Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
d.Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

Enrolled as HVM providers under the Physical Disability Waiver as described in IAC 441 41:
a.Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
b.Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

Enrolled to provide HVM services under the Elderly Waiver described in IAC 441 Chapter 33:
a. Area agencies on aging as designated in 17—4.4(231).
b. Community action agencies as designated in Iowa Code section 216A.93.
c. Providers eligible to participate as home and vehicle modification providers under the health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

Enrolled to provide HVM services under the Brain Injury Waiver as described in IAC 441 Chapter 39:
a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.
b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The IMMT service is used by members with medical needs and covers the time when state plan medical services, including EPSDT cannot be used, e.g., supervising and monitoring the member between medical interventions or treatment such s monitoring for suctioning a trach or for seizures that do not occur on a regular basis but need intervention when they occur. The services must be needed to allow the members usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver. The services under the Intellectual Disability waiver, including interim medical monitoring and treatment services, are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
a. Service requirements. Interim medical monitoring and treatment services shall:
(1) Provide experiences for each members social, emotional, intellectual, and physical
development;
(2) Include comprehensive developmental care and any special services for a member with special
needs; and
(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.
(4) Be in need as ordered by a physician
(5) Be monitored to assure it is not used as childcare.
b. Interim medical monitoring and treatment services may include supervision to and from school, but not the cost of the transportation.

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:

Limitations.
(1) A maximum of 48, 15 - minute units of service is available per day.
(2) Covered services do not include a complete nutritional regimen.
(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or
waiver services, including EPSDT services, provided under the state plan.
(4) Interim medical monitoring and treatment services may be provided only in the member's
home, in a registered group child care home, in a registered family child care home, in a licensed child
care center, or during transportation to and from school.
(5) The staff-to-member ratio shall not be greater than one to six.
d. A unit of service is a 15 minute unit.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Community Living providers
Agency	Childcare Facility

Provider Category	Provider Type Title
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interim Medical Monitoring and Treatment

Provider Category:
Agency
Provider Type:

Supported Community Living providers

Provider Qualifications
License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

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

Provider Category:
Agency
Provider Type:

Childcare Facility

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Home health agencies certified to participate in the Medicare program.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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:**

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

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 services under Medical Day Care for Children are limited to additional services not otherwise covered under the state plan, including childcare medical services and EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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: 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:

Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Eligible Home Care agencies are those that meet the conditions set forth in Iowa Administrative CodeChapter 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:

Childcare Facility

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Childcare Facilities that are defined as childcare 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

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response or Portable Locator System

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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	Emergency Response System Providers

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Emergency Response System Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies which meet the conditions of participation for Emergency Response System Providers as set forth in Iowa Administrative Code 77.33(2).

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.
b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.
c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.
d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.
e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

Service Definition *(Scope):*

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

Supported Community Living (SCL) services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan. Available services: personal and home skills training, individual advocacy, community skills training, personal environment support, transportation, and treatment. 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 meals; ability to use community resources such as public transportation, libraries, etc., and ability to select foods at a 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 in order to allow the person to function in the least restrictive environment.

The cost of transportation services is provided through the tiered rate fee schedule funding. Transportation services are used to conduct business errands and essential shopping, travel to and from work or day programs, and to assist the person to travel from one place to another to obtain services or carry out life's activities. Transportation, the waiver service, is not available to members accessing daily SCL services.

Treatment services means activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning.
Treatment services include physical or physiological treatment and psychotherapeutic treatment.
1.Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.
2.Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person's functioning in response to the physical, emotional, and social environment.

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 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 IDT the member's ability to be supported safely through remote support is identified.
Through an assessment by the remote support provider with input from the individual and their IDT, the location of the devices or monitors will be determined to best meet the individual's needs.

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

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.

Administrative cost of the assessment is part of the person-centered planning process.

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.

For additional service specifications for Remote Support and Telehealth, see Main: B. Optional

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 30 days and the member's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision. Daily SCL services are reimbursed by a tiered rate fee schedule based on a member’s assessed need.
(2) 15-minute units when subparagraph (1) does not apply. 15-minute unit reimbursement amounts cannot exceed the fee schedule caps published in the Iowa Administrative Code 41-77.79(1)

For daily SCL, providers are reimbursed using a tiered rate fee schedule. The cost of all transportation, excluding NEMT transportation, is included in the daily SCL unit rate. The specific member support needs must be identified in the member’s service plan and the provider must maintain records to support the expenditures.

The maximum number of units available per member is as follows:
(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.
(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.
h. The service shall be identified in the member's individual comprehensive plan.
i. Services shall not be simultaneously reimbursed with other residential services, HCBS ID respite, Medicaid or HCBS ID nursing, or Medicaid or HCBS ID home health aide services.

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

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	Licensed Foster Care
Agency	Foster Family Home Subcontractors
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:

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 441-77.37

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:

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 441-77.37

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:

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

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:**

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

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

Service Definition *(Scope):*

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

Transportation services may be provided for members to conduct business errands, essential shopping, and to reduce social isolation. Whenever possible, natural supports (family, neighbors, or friends) or community agencies which can provide this service without charge are utilized. This service does not include transportation to medical services. As part to the annual person centered planning process, the member's interdisciplinary team identifies transportation needs of the member and identifies paid or unpaid resources to meet the needs.

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 one mile or one one-way trip. The member's service plan will show how the member's health care needs are being met. Services must be authorized in the service plan. The case manager will monitor the plan.

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

Members accessing daily SCL and RBSCL services may have transportation services authorized in the member services plan. All transportation, excluding NEMT and transportation to and from school, will be provided through the daily SCL or RBSCL service.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Facilities
Agency	Area Agencies on Aging
Agency	Regional Transit Agencies
Agency	Commuity Action Agency
Agency	Supported Community Living Providers

Provider Category	Provider Type Title
Agency	Provider Contracting with NEMT
Agency	Subcontactor with Area Agency on Aging
Agency	County Contracted Transportation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:

Nursing Facilities
Provider Qualifications
License *(specify):*

Licensed and inspected under Iowa Code Chapter 135C and an enrolled Medicaid provider as described in IAC 441 Chapter 81.
Certificate *(specify):*

Other Standard *(specify):*

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:

Area Agencies on Aging
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Area Agencies on Aging as designated by the Department on Aging in 17—4.4(231).

Verification of Provider Qualifications

Entity Responsible for Verification:

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 Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

As designated by the Iowa Department of Transportation in the Code of Iowa 28M.
28M.1 Regional transit district defined.
"Regional transit district" means a public transit district created by agreement pursuant to chapter 28E by one or more counties and participating cities to provide support for transportation of passengers by one or more public transit systems which may be designated as a public transit system under chapter 324A.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education beyond those implemented by the contracting agency or provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

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:

Commuity Action Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Community Action Agencies as designated in Iowa Code section 216A.93

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:

Supported Community Living Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers certified by the HCBS Quality Oversight Unit to provide supported community living under the ID and BI Waiver pursuant to Iowa Administrative Code 441 - 77.37 and 77.39.

Verification of Provider Qualifications

Entity Responsible for Verification:

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:

Provider Contracting with NEMT

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Transportation providers contracting with the nonemergency medical transportation contractor.

Verification of Provider Qualifications

Entity Responsible for Verification:

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:

Subcontactor with Area Agency on Aging

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

Verification of Provider Qualifications
Entity Responsible for Verification:

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:

County Contracted Transportation Provider

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Transportation providers that contract with county governments.

Verification of Provider Qualifications

Entity Responsible for Verification:

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
Case managers or community based case managers provide case management services for members enrolled in the State's §1915(c) Intellectual Disability Waiver. Services are reimbursed through an administrative function of HHS.

All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned.

MCO
MCO community-based case managers provide case management services to all members receiving HCBS. MCOs ensure ease of access and responsiveness for each member to their community-based case manager during regular business hours and, at a minimum, the community-based case manager contacts members at least monthly, either in person or by phone, with an interval of at least fourteen calendar days between contacts.

MCO community-based case managers provide case management services to all members receiving HCBS. MCOs ensure ease of access and responsiveness for each member to their community-based case manager during regular business hours and, at a minimum, the community-based case manager or integrated health home care coordinator contacts members at least monthly, either in person or by phone, with an interval of at least fourteen calendar days between contacts.

All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned. MCOs are contractually required to ensure the delivery of services in a conflict free manner consistent with Balancing Incentive Program requirements. HHS approves and monitors all MCO policies and procedures to ensure compliance.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

1. For purposes of this section and section 249A.30 unless the context otherwise requires:
a. “Member” means an individual approved by the department to receive services under a waiver.
b. “Provider” means an agency certified by the department to provide services under a waiver.
c. “Waiver” means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2. If a person is being considered by a provider for employment involving direct responsibility for a member (individual approved by the department to receive services under a waiver) or with access to a member when the member is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department [The Department of Health and Human Services, Iowa Medicaid] shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

As part of the provider’s self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the criminal background checks. The provider agency is responsible for completing the required waiver to perform the criminal background check and submitting to the Department of Public Safety who conducts the check. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of criminal background checks are available to the Department upon request. The 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. During each of these review processes, the HCBS Quality Oversight unit reviews the provider’s quality data collected by the provider to measure compliance with the criminal background checks. The HCBS Quality oversight unit also reviews a random sample of personnel files to verify the background checks are present in the file and reflects the provider’s quality review.

The State HCBS Quality Oversight Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. There are four types of provider site visits where agency personnel records are reviewed; periodic, certification, focused and targeted. At a minimum all providers have a periodic review conducted every five years. Providers of supported community living, and respite services require a certification review that is conducted every one to three years, depending on the results of the review. Focused reviews occurs annually for a select group of providers randomly selected to review a quality topic selected by the Department. Targeted reviews are conducted as needed based on complaints received by the Department or specific provider quality concerns identified.

Criminal history and abuse registry screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. 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."Member" means an individual approved by the department to receive services under a waiver.
b."Provider" means an agency certified by the department to provide services under a waiver.
c."Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2.If a person is being considered by a provider for employment involving direct responsibility for a member (individual approved by the department to receive services under a waiver) or with access to a member when the member is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3.If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
4.If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

Individual Consumer Directed Attendant Care (CDAC) is the only service that allows individuals to be providers. All 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 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 Department of Health and Human Services, Iowa Medicaid 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 an 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. The 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 case managers and community based case managers, market to qualified providers to enroll in Medicaid.

MCOs are responsible for oversight of their provider networks. The State retains authority for development of the performance standards, and for review and approval of any disenrollment recommendations.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
QP-a1: 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):
Other
If 'Other' is selected, specify:
Enrollment information out of IoWANS. All MCO HCBS providers must be enrolled as verified by the 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	**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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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 the Iowa Medicaid Provider Services Unit every five 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: 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: Contracted entity	**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, Institutional and Waiver Authorization and Narrative System (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: 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	**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:

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	**Other**

	Ongoing	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 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:

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

The 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 Iowa Medicaid, then that provider is no longer eligible to enroll with an MCO.

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

Responsible Party *(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.

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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Service planning responsibilities for FFS members in the ID Waiver is completed by HHS Targeted Cases Management. HHS TCM is an arm of the HHS Mental Health and Disability Services. HHS TCM is CARF certified for case management. HHS targeted case managers (TCM) must be licensed social workers.

TCM qualifications include: graduation from an accredited four-year college or university; or the equivalent of four years of full-time technical work experience involving direct contact with people in overcoming their social, economic, psychological, or health problems; or an equivalent combination of education and experience substituting the equivalent of one year of full-time qualifying work experience for one year (thirty semester or equivalent hours) of the required education to a maximum substitution of four years.

In addition, HHS TCMs may be required to have the following specified experience in the following areas if they are specifically working with these populations:

- Developmental disabilities: a minimum of one-year full-time (or equivalent part-time) experience in delivering or coordinating services for persons with developmental disabilities (i.e., severe, chronic mental or physical impairments). Positions that meet the intellectual disability background noted above will normally meet this selective area too. Experience in providing services and treatment to autistic children or persons with epilepsy or cerebral palsy will also qualify.
- Intellectual disability: a minimum of one year of full-time (or equivalent part-time) experience in delivering or coordinating services for persons with significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior manifested during the developmental period.

MCO
MCO community-based case managers develop service plans for members receiving HCBS waiver services. MCOs community-based case managers are required to meet the same HHS TCM qualifications, requirements, and be accredited as specified in 441 Iowa Administrative Code Chapter 24 as listed above in this section.n.

Social Worker
Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Information related to waiver services and general waiver descriptions are initially made available following receipt of a waiver application. Service plans are then developed with the member and an interdisciplinary team, regardless of delivery system. Teams often consist of the member and, if appropriate, their representative; case manager or community-based case manager; service providers; and other supporting persons selected by the member. During service plan development, the member and/or their representative is strongly encouraged to engage in an informed choice of services, and is offered a choice of institutional or HCBS. Planning is timely, occurs when convenient for the member, and is intended to reflect the member's cultural considerations. If the member chooses to self-direct services, an Independent Support Broker is provided to assist with budgeting and employer functions.

Iowa Medicaid Member Services Unit remains available at all times, during normal business hours, to answer questions and offer support to all Medicaid beneficiaries. Iowa Medicaid QIO MSU remains available to answer questions and offer support. Further, the QIO MSU distributes a quarterly newsletter in effort to continually educate participants about services and supports that are available but may not have been identified during the service plan development process.

The fee-for-service person-centered planning processes must:

- Include people chosen by the member;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and
- Record the alternative home and community-based settings that were considered by the member.

MCOs are contractually required to provide supports and information that encourage members to direct, and be actively engaged in, the service plan development process, and to ensure that members have the authority to determine who is included in the process. Specifically, MCO person-centered planning processes must:
- Include people chosen by the member;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the member and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and
- Record the alternative home and community-based settings that were considered by the member.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-

centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

For fee-for-service members, service plans are developed by the member; HHS case manager and an interdisciplinary team. Planning meetings are scheduled at times and locations convenient for the member. The service plan must be completed prior to services being delivered and annually thereafter, or whenever there is a significant change in the member's situation or condition. The case manager receives the assessment and level of care determination from the Iowa Medicaid Medical Services Unit. A summary of the assessment becomes part of the service plan. The case manager uses information gathered from the assessment and then works with the member to identify individual and family strengths, needs, capacities, preferences and desired outcomes and health status and risk factors. This is used to identify the scope of services needed.

Note: For both FFS and managed care enrollees, the interRAI Intellectual Disability (interRAI-ID) and Child and Youth Mental Health and Developmental Disability (ChYMH-DD) is used to assess members accessing the ID waiver. The interRAI is a valid and reliable assessment tool specifically designed as a lifespan approach to the evaluation of each member's needs, strengths and preferences to lead normal, independent, and quality lives in society. interRAI-ID and ChYMH-DD measures the member's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. The interRAI-ID and ChYMH-DD was designed to integrate into person-centered planning processes that help all members identify their unique preferences, skills, and life goals. The interRAI-ID and ChYMH-DD reviews a wide range of areas, including but not limited to, community and social involvement, strengths, relationships and supports, independence in everyday activities and cognition and executive functioning. Both the interRAI-ID and ChYMH-DD tools are coded using observations across specific timeframes and include multiple scales and algorithms to capture risk levels across areas of need to derive measures of functional status. Collaborative Action Plans (CAPs), evidence informed treatment guidelines, are used to help the interdisciplinary team to identify areas of need and prioritize services.

The case manager informs the member of all available non-Medicaid and Medicaid services including waiver services. There are waiver informational brochures available to share with members and their parents/guardians. Information is also available on the Iowa Medicaid and MCO websites. The brochures include information on eligibility, service descriptions, and the application process. Once a member begins the enrollment process and has a case manager or community-based case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a member's plan of care.

The case manager will also discuss with the member the self-direction option and give the member the option of self-directing services available. The member and the interdisciplinary team choose services and supports that meet the member's needs and preferences, which become part of the service plan. Service plans must:

-Reflect that the setting in which the member resides is chosen by the member;
-Reflect the member's strengths and preferences;
-Reflect the clinical and support needs as identified through the needs assessment;
-Include individually identified goals and desired outcomes which are observable and measurable;
-Include the interventions and supports needed to meet member's goals and incremental action steps as appropriate;
-Reflect the services and supports, both paid and unpaid, that will assist the member to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
-Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
-Include the identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
-Include a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications;
-Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
-Include a plan for emergencies;
-Be understandable to the member receiving services and supports, and the individuals important in supporting the member;
-Identify the individual and/or entity responsible for monitoring the plan;
-Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;
-Be distributed to the member and other people involved in the plan;
-Indicate if the member has elected to self-direct services and, as applicable, which services the member elects to self-

direct; and
-Prevent the provision of unnecessary or inappropriate services and supports.

The case manager will be responsible for coordination, monitoring and overseeing the implementation of the service plan including Medicaid and non-Medicaid services. If a member chooses to self-direct, the member, with the help of a case manager identifies who will be providing Independent Support Broker Services.

For MCO members, service plans are developed through a person-centered planning process led by the member, with MCO participation, and representatives included in a participatory role as needed and/or defined by the member. Planning meetings are scheduled at times and locations convenient for the member. A team is established to identify services based on the member's needs and desires, as well as availability and appropriateness of services. The team is also responsible for identifying an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or when the member's needs change. Service plans are completed prior to services being delivered, and are reevaluated at least annually, whenever there is a significant change in the member's situation or condition, or at a member's request. Risk assessments and mitigation plans are completed during the member's service plan (ISP) team meeting. The community based case manager determines a members risk through a series of questions and answers. Findings are documented in the Person Centered Treatment Plan. This form guides the community based case manager to identify member's personal preferences for risk mitigation including back-up arrangements. The community based case manager leads the ISP meeting, ensuring that there is a back-up arrangement for each service identified. The member, ISP team, and ancillary providers receive a copy of the plan.

In accordance with 42 CFR 441.301 and 441 Iowa Administrative Code Chapters 90.5(1)b and 83, MCOs must ensure the service plan reflects the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan must reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports. The service planning process must address the full array of medical and non-medical services and supports provided by the MCO and available in the community to ensure the maximum degree of integration and the best possible health outcomes and member satisfaction. Services plans must:

-Reflect that the setting in which the member resides is chosen by the member;
-Reflect the member's strengths and preferences;
-Reflect the clinical and support needs as identified through the needs assessment;
-Include individually identified goals and desired outcomes which are observable and measurable;
-Include the interventions and supports needed to meet members' goals and incremental action steps as appropriate;
-Reflect the services and supports, both paid and unpaid, that will assist the member to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
-Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
-Include the identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
-Include a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications;
-Reflect risk factors and measures in place to minimize them, including individualized back- up plans and strategies when needed;
-Include a plan for emergencies;
-Be understandable to the member receiving services and supports, and the individuals important in supporting him or her;
-Identify the individual and/or entity responsible for monitoring the plan;
-Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;
-Be distributed to the member and other people involved in the plan;
-Indicate if the member has elected to self-direct services and, as applicable, which services the member elects to self-direct; and
-Prevent the provision of unnecessary or inappropriate services and supports.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the evaluation/reevaluation of level of care, risks are assessed for FFS members by a case manager and for MCO members by their respective MCO, using the assessment tools designated in B-6e. The assessment becomes part of the service plan and any risks are addressed as part of the service plan development process. The comprehensive service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. In addition, providers of applicable services shall provide for emergency backup staff. All service plans must include a plan for emergencies and identification of the supports available to the member in an emergency.

Emergencies are those situations for which no approved individual program plan exists and which, if not addressed, may result in injury or harm to the member or other persons or significant amounts of property damage.

Personal Emergency Response and Portable Locator Services are available under the waiver and it is encouraged that this service be used as part of emergency backup plan. Other providers may be listed on the service plan as source of back up as well. All members choosing the self-direction option will sign an individual risk agreement that permits the member to acknowledge and accept certain responsibilities for addressing risks.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

While information about qualified and accessible providers is available to members through the Iowa Mediciad website, MCO website, and/or MCO Member Services call center, the case manager or community-based case manager first identifies providers to the member and their interdisciplinary team during the person-centered service planning process. Members are encouraged to meet with available providers before making a selection, and members are not restricted to choosing providers within their community. If an MCO is unable to provide services to a particular member using contract providers, the MCO is required to adequately and timely cover these services for that member using non-contract providers, for as long as the MCO's provider network is unable to provide them.

The MCOs are responsible for authorizing services for out-of-network care when they do not have an in-network provider available within the contractually required time, distance and appointment availability standards. The MCO is responsible for assisting the member in locating an out-of-network provider, authorizing the service and assisting the member in accessing the service. The MCO will also assist with assuring continuity of care when an in-network provider becomes available. To ensure robust provider networks for members to choose from, MCOs are not permitted to close provider networks until adequacy is fully demonstrated to, and approved by, the State. Further, members will be permitted to change MCOs in the event that their chosen provider does not ultimately contract with their MCO. Finally, MCOs are required to submit to the State on a regular basis provider network reports including, but not limited to network geo-access reports, 24- hour availability audit reports, provider-credentialing reports, subcontractor compliance summary reports, and provider helpline performance reports.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

HHS has developed a computer program named the Institutional and Waiver Authorization and Narrative System (IoWANS) to support HCBS programs. This system assists HHS with tracking information, monitoring, and approving service plans for fee-for-service members. (Refer to appendix A and H for IoWANS system processes.) On a monthly basis, Iowa Medicaid QIO MSU conducts service plan reviews. The selection size for the waiver has a 95% confidence level. This information is reported to CMS as part of Iowa's performance measures. The State retains oversight of the MCO service plan process through a variety of monitoring and oversight strategies as described in Appendix D – Quality Improvement: Service Plan section. IoWANS will only be utilized for fee-for-service members and quality data for managed care participants will be provided by the MCOs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

Medicaid agency

Operating agency

Case manager

Other

Specify:

HHS case managers maintain fee-for-service participant service plans. MCO community-based case managers maintain MCO member service plans.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

FFS
The case managers are responsible for monitoring the implementation of the service plan and the health and welfare of fee-for-service members, including:
- Monitoring service utilization.
- Making at least one contact per month with the member, the member's legal representative, the member's family, service providers, or another person, as necessary to develop or monitor the treatment plan.
- Make a face-to-face contact with the member at least once every three months.
- Participation in the development and approval of the service plan in coordination with the interdisciplinary team at least annually or as needs change. If services have not been meeting member needs, the plan is changed to meet those needs. The effectiveness of the emergency backup plan is also addressed as the service plan is developed.

The member is encouraged during the time of the service plan development to call the case manager if there are any problems with either Medicaid or non-Medicaid services. The case manager will then follow up to solve any problems. Monitoring service utilization includes verifying that:
- The member used the waiver service at least once a calendar quarter.
- The services were provided in accordance with the plan.
- The member is receiving the level of service needed.

The IoWANS system is also used to assist with tracking information, monitoring services, and assuring services were provided to fee-for-service members. If the member is not receiving services according to the plan or not receiving the services needed, the member and other interdisciplinary team members and providers are contacted immediately.

The HCBS Specialists (of the HCBS Quality Oversight Unit) monitor the how member health and welfare is safeguarded, the degree of service plan implementation; and the degree of interdisciplinary team involvement of the case manager during the HCBS Quality Assurance review. Members are asked about their choice of provider, whether or not the services are meeting their needs, whether staff and care coordinators are respecting their choice and dignity, if they are satisfied with their services and providers, or whether they feel safe where they receive services and live.

The HCBS Specialists also review the effectiveness of emergency back-up and crisis plans. These components are monitored through quality oversight reviews of providers, member satisfaction surveys, complaint investigation, and critical incident report follow-up. All providers are reviewed at least once over a five-year cycle and members are surveyed at a 95% confidence level. Information about monitoring results are compiled by the HCBS Quality Assurance and Technical Assistance Unit on a quarterly basis. This information is used to make recommendations for improvements and training.

The Iowa Medicaid MSU also conducts quality assurance reviews of member service plans at a 95% confidence level. These reviews focus on the plan development, implementation, monitoring, and documentation that is completed by the case manager, CBCM, or health home coordinator. All service plans reviewed are assessed for member participation, whether the member needs are accurately identified and addressed, the effectiveness of risk assessments and crisis plans, member access to waiver and non-waiver services, as well as coordination across providers to best serve the member's needs. Information about monitoring results are compiled by the Iowa Medicaid MSU on a quarterly basis. This information is used to make recommendations for improvements and training.

MCO
MCOs are responsible for monitoring the implementation of the service plan, including access to waiver and non-waiver services, the quality of service delivery, and the health, safety and welfare of members and choice of service providers. After the initiation of services identified in a member's service plan, MCOs monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan. At minimum, the care coordinator must contact members within five business days of scheduled initiation of services to confirm that services are being provided and that member's needs are being met. At a minimum, the community-based case manager shall contact 1915(c) HCBS waiver members at least monthly either in person or by telephone with an interval of at least fourteen (14) calendar days between contacts. Members shall be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least sixty (60) days between visits.

MCOs also identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively. If problems are identified, MCOs complete a self-assessment to determine what additional supports, if any, could be made available to assist the member. MCOs must develop methods for prompt follow-up and remediation of

identified problems; policies and procedures regarding required timeframes for follow-up and remediation must be submitted to HHS for review and approval. Finally, any changes to a member's risk are identified through an update to the member's risk agreement. MCOs must report on monitoring results to the State.

In the event of non-compliance with service plan timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues.

If the MCO fails to develop a plan of care for HCBS waiver enrollees within the timeframe mutually agreed upon between the MCO and the Agency in the course of Contract negotiations the MCO will be assessed a noncompliance fee of $315 per occurrence.

HHS case managers maintain fee-for-service participant service plans. MCO community-based case managers maintain MCO member service plans. Service plans are maintained for a minimum of five years post service.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
SP-a1: Number and percent of service plans that accurately address all the member's assessed needs, including at a minimum, health and safety risk factors, and personal goals Numerator: # of service plans that accurately address all the member's assessed needs, including at a minimum, health and safety risk factors, and personal goals Denominator: # of reviewed service plans.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
person-centered plans and the results of the department approved assessment

Responsible Party for data collection/generation *(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 = 95% confidence level with +/- 5% margin of error
Other Specify: Contracted Entity including MCO	**Annually**	**Stratified** Describe Group: IA.0299 - BI (6%) IA.0213-AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	Continuously and	**Other**

	Ongoing	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 service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:
SP-c1: Number and percent of CAHPS respondents who responded "YES" on the CAHPS survey to question 53 "In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?". Please see Main: Optional for the full description, including the Numerator and Denominator

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
FFS CAHPS and MCO CAHPS databases

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify: Contracted Entity including MCO	**Annually**	**Stratified** Describe Group:

		IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	Continuously and Ongoing	**Other** Specify:
	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:
SP-c2: Number and percent of service plans which are updated on or before the member's annual due date. Numerator: # of service plans which were updated on or before the member's annual due date; Denominator: # service plans due for annual update that were reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
person-centered plans and the results of the department approved assessment

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify: Medicaid contracted entity including MCO	**Annually**	**Stratified** Describe Group:

		IA.0299 - BI (6%) IA.0213-AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	Continuously and Ongoing	**Other** Specify:
	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):*

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
SP-d1: Number and percent of members whose services were delivered according to the service plan, including type, scope, amount, duration, and frequency specified in the plan. Numerator: # of members whose services were delivered according to the service plan, including type, scope, amount, duration, and frequency specified in the plan. Denominator: # of member's service plans reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Service plans are requested from the case managers, with service provision documentation requested from providers

Responsible Party for data collection/generation *(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 =

		95% confidence level with +/- 5% margin of error
Other Specify: Contracted Entity including MCO	**Annually**	**Stratified** Describe Group: IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	Continuously and Ongoing	**Other** Specify:
	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**

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
SP-e1: Number and percent of CAHPS respondents who responded with either “MOST” or "ALL" on the CAHPS survey to question 56 “In the last 3 months, did your service plan include . . . of the things that are important to you”. For Full description see Main B Optional

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
FFS CAHPS and MCO CAHPS databases

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =

		95% confidence level with +/- 5% margin of error
Other Specify: Contracted entity including MCO	**Annually**	**Stratified** Describe Group: IA.0299 - BI (6%) IA.0213-AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	Continuously and Ongoing	**Other** Specify:
	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**

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

Performance Measure:
SP-e2: Number and percent of service plans from the HCBS QA survey review that indicated the member had a choice of HCBS service providers Numerator: Number of service plans from the HCBS QA survey review that indicated the member had a choice of HCBS service providers.; Denominator: Total number of service plans from the HCBS QA survey that were reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
FFS QA review of service plan stored in OnBase. MCO review services plans available through their system.

Responsible Party for data collection/generation *(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 = 95% confidence level with +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:

Medicaid contracted entity, including MCO		IA.0299 - BI (6%) IA.0213-AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	Continuously and Ongoing	**Other** Specify:
	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):*

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

The HCBS Quality Oversight Unit has identified questions and answers on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home and Community-Based Services Survey that demand additional attention. If member answers 'No or I don't know' to an identified CAHPS question, a follow-up letter is sent to the case manager to ensure the member is participating in Person Centered Planning. This assures 100% follow up with the member's case manager on all responses to the identified question.

Data and results obtained by the HCBS QIO unit are reviewed by the Quality Assurance Committee at least annually. Results from the CAHPS and service plan Ride Along process are reviewed for issues and trends that may require corrective actions plans development. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

b. Methods for Remediation/Fixing Individual Problems

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

The Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. MCOs are responsible for oversite of service plans for their members.

The HCBS QIO has identified CAHPS questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager.

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

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 Entities including MCOs	**Annually**
	Continuously and Ongoing

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

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Iowa offers two self-direction services the Consumer Choices Option (CCO) and Consumer Directed Attendant Care (CDAC) service.

Consumer Choices Option (CCO)

The CCO offers both employer and budget authority to the member self-directing services. Members are given information about the CCO program at the initial person centered service plan meeting and at the subsequent annual service plan meetings thereafter. At the time of service plan development and/or at the member's request, the member has the option to convert the following ID Waiver services into an individualized self-direction budget based on services that are authorized in their service plan: (1) consumer directed attendant care (unskilled); (2) day habilitation; (3) home and vehicle modification; (4) prevocational services;(5) basic individual respite care; (6) supported community living; (7) supported employment; and (8) transportation.

CCO gives members control over a targeted amount of waiver dollars. Under CCO a member may convert specific waiver services that have been authorized in the member's service plan to create an individual monthly budget. Members that choose to use CCO will use the individual monthly budget to meet their assessed needs by directly hiring employees or purchase other goods and services. A member may use the following three types of self-direction services to meet their assessed needs: (1) self-directed personal care services; (2) self-directed community supports and employment; and (3) individual-directed goods and services.

CCO information is also available on the HHS website and has a dedicated CCO webpage.

Self-directed Community Supports and Employment are services that support the member in developing and maintaining life and community integration. Individual-directed goods and services are services, equipment or supplies not otherwise provided through the Medicaid State Plan that address an identified need in the member's service plan. The items or services would decrease the need for other Medicaid services, and/or promote inclusion in the community, and/or increase the member's safety in the community or home.

Members have authority over the individual authorized budget to perform the following tasks:
• contract with entities to provide services and support;
• determine the amount to be paid for services with the exception of the independent support broker and the financial management service whereas reimbursement rates are subject to the limits in 441 Iowa Administrative Code Chapter 79.1(2);
• schedule the provision for services;
• authorize payment for waiver goods and services identified in the individual budget; and
• reallocate funds among services included in the budget. Individual monthly budget development includes the costs of the FMS, ISB, and any services and supports chosen by the member as optional service components.

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

All members choosing CCO work with an ISB who will help them plan for their individual budget and services. The ISB works at the direction of the member and assists the member with their budget. The ISB is required to attend an ISB training prior working with members. The ISB cannot be the guardian, power of attorney, or a provider of service to the member, to avoid potential conflicts of interest. The ISB performs the following services as directed by the member or the member's representative:

• Assist with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
• Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
• Complete the required employment packet with the financial management service.
• Assist with interviewing potential employees and entities providing services and supports if requested by the member.

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

• Assist with negotiating with entities providing services and supports if requested by the member.
• Assist with contracts and payment methods for services and supports if requested by the member.
• Assist with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
• Review expenditure reports from the FMS to ensure that services and supports in the individual budget are being provided.
• Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member."

Members will also work with a Financial Management Service (FMS) provider that will receive Medicaid funds on behalf of the member. The FMS is the employer of record and performs all of the following services:

• Receive Medicaid funds in an electronic transfer.
• Process and pay invoices for approved goods and services included in the individual budget.
• Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
• Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
• Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
• Verify for the member an employee's citizenship or alien status.
• Assist with fiscal and payroll-related responsibilities including, but not limited to:
o Verifying that hourly wages comply with federal and state labor rules.
o Collecting and processing timecards.
o Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
o Computing and processing other withholdings, as applicable.
o Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
o Preparing and issuing employee payroll checks.
o Preparing and disbursing IRS Forms W-2 and W-3 annually.
o Processing federal advance earned income tax credit for eligible employees.
o Refunding over-collected FICA, when appropriate.
o Refunding over-collected FUTA, when appropriate.

• Assist the member in completing required federal, state, and local tax and insurance forms.
• Establish and manage documents and files for the member and the member's employees.
• Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
• Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
• Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
• Establish a customer services complaint reporting system.
• Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
• Develop a business continuity plan in the case of emergencies and natural disasters.
• Provide to the department an annual independent audit of the financial management service.
• Assist in implementing the state's quality management strategy related to the financial management service."

To determine the monthly CCO budget amount, a "cap amount" and "budget amount" are calculated by the Iowa Medicaid for each waiver service that can be used in the CCO program. The calculations are does to assure cost neutrality of the CCO program, i.e., that using CCO will not cost more than using traditional service purchased from an enrolled HCBS service provider. Annually, the Department determines the average service cost by identifying the individual provider service costs as identified in the member service plans. The average service cost is used to determine the "cap amount" of the CCO budget. The cap amount for a service is considered what the service would cost if CCO was not being used and the service was included in the individual member service plan.
The cap amount is used to ensure the member stays within the program dollar cap limits within each waiver. This

includes the monthly cap on the total services by waiver, e.g., the monthly cap on the Brain Injury or Physical Disability Waivers. The waiver program cap limits are also applied to services specific cost limits, e.g., the monthly cap on supported employment services costs. The ID Waiver does not have total services monthly cap, but does have limits on the amount of supported Employment and home and vehicle modifications that are available for use. The service specific limits are identified in the service descriptions in Appendix C.

The department also determines the percentage of services that are used, compared to what is authorized within a waiver service plan. This is done to identify the average amount of services that are authorized in a service plan but not used. The Iowa Medicaid calculates this by comparing the amount of service that is authorized in each member service plan to the amount of the service that is billed in the MMIS system. This percentage is applied to the service cap amount to determine the CCO "budget amount". The budget amount is the total funds available to the member in the monthly CCO budget for the member to manage.

The member may choose to set aside a certain amount of the budget each month to save towards purchasing additional goods or services they cannot buy from the normal monthly budget. A savings plan must be developed by the member and approved by HHS prior to implementation. The good or service being saved for must be an assessed need identified in the member's service plan.

Consumer Directed Attendant Care (CDAC)

The CDAC service began in Iowa in 1996 and was the first attempt by the State to offer self-directed services. CDAC is a self-directed service that offers the member employer authority only. There are two CDAC services—skilled and unskilled. See Appendix C for service description and provider qualifications. All CDAC providers are enrolled Medicaid providers and may be an individual employee or an agency. There are no FMS or ISB services to support the CDAC service and the enrolled CDAC provider performs all billing through the Medicaid MMIS systems. The Iowa Medicaid Provider Services Unit has dedicated staff available to address CDAC issues and support the Individual CDAC provider with billing. The member's case manager is available to support the member when using CDAC services. The member is responsible for completing the CDAC agreement with the CDAC provider. The CDAC agreement identifies the personal care services that will be performed. The member is responsible for hiring, directing, and supervising the CDAC provider to assure their identified needs are being met. Members are also responsible for signing CDAC timecards to allow payment for services.
Nonskilled CDAC services are limited to help with activities such as dressing bathing, personal hygiene, toileting, meal preparation, etc. A full description of CDAC supports are listed in Appendix C.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

Participant: Employer Authority. As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where

services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

CCO may be provided to a member residing in their own home, with family, or in homes with less than three members living together and receiving HCBS services in the community. HHS does not allow the use of self-direction services to members living in licensed residential care facilities (RCFs).

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Self-direction training and outreach materials are available through the Iowa Medicaid website and MCOs. Materials include information on the benefits, responsibilities, and liabilities of self-direction. A brochure about this option has been developed and includes information about the benefits, responsibilities, and liabilities. This brochure is available at all the local HHS offices, the HHS website, and has been distributed to other community agencies. The participant may also call Iowa Medicaid Member Services and request to have the brochure mailed directly to them. All members must sign an informed consent contract and a risk agreement that permits the member to acknowledge and accept certain responsibilities for addressing risks.

The case manager or community-based case manager is required to discuss this option along with the benefits, responsibilities and liabilities at the time of the service plan development and/or any time the member's needs change. This results in information about self- direction activities being reviewed, at least annually, with the member. This option is intended to be very flexible; members can choose this option at any time. Once given information about this option, the member can immediately elect this option, or can elect to continue or start with traditional services initially and then change to self-direction at a later date.

MCOs must also provide ongoing member or representative training upon request and/or if it is determined a member needs additional training. Training programs are designed to address the following: (i) understanding the role of members and/or representatives in self-direction; (ii) selecting and terminating providers; (iii) being an employer and managing employees; (iv) conducting administrative tasks such as staff evaluations and approval of time sheets; (v) scheduling providers; and (vi) back-up planning. All MCO training and education materials are subject to review and approval by the State.

To give the member an opportunity to locate providers and supports, the service plan can reflect that traditional services will begin at the start date of the service plan and the self-directed services and supports will begin at a later date. This does not require a change in the service plan. Members can elect self-direction and then elect to go back to traditional services at any time. The case manager or community-based case manager is responsible for informing the member of their rights and responsibilities. All self-directed services and supports must begin on the first of a month.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: *(check each that applies)*:

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Services may be self-directed by a non-legal representative freely chosen by an adult member. The policies described in this section apply to both the fee-for-service and managed care delivery systems. If the member selects a non-legal representative, the representative cannot be a paid provider of services and must be eighteen years or age or older. The member and the representative must sign a consent form designating who they have chosen as their representative and what responsibilities the representative will have. The choice must be documented in the member's file and provided to the member and their representative. At a minimum, the representative's responsibilities include ensuring decisions made do not jeopardize the health and welfare of the member and ensuring decisions made do not financially exploit the member.

The Iowa Medicaid uses a quality assurance process to interview members in order to determine whether or not the representative has been working in their best interest. The interviews are completed primarily by telephone and may be completed in-person if requested. The interviews are conducted as an ongoing QA activity and are used to ensure that a member's needs are met and that services are provided. QA interviews are completed monthly with a randomly selected representative sample of members. The interview sample selection size assures a 95% confidence level in the results of the interviews.

In addition, the Independent Support Broker provides monitoring of health and safety. The member's case manager or community based case manager is responsible to assess individual needs and monitor service delivery to assure that the member's health and safety are being addressed. Case managers or community based case managers routinely review how services are being provided and monitor services to assure the member's needs are being met, including how the representative is performing.

MCOs are contractually required to maintain quality assurance processes to ensure that the representative functions in the best interest of the member. These quality assurance processes are subject to HHS review and approval and include, but are not limited to, monthly member interviews, to assess whether a non-legal representative is working in the best interest of the member. HHS provides additional oversight in accordance with the HCBS quality improvement strategy.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Self Directed Community Support and Employment		
Adult Day Care		
Consumer Directed Attendant Care (CDAC) - unskilled		
Supported Community Living		
Home and Vehicle Modification		
Prevocational Services		
Individual Directed Goods and Services		
Day Habilitation		
Self Directed Personal Care		
Consumer Directed Attendant Care (CDAC) - skilled		
Medical Day Care for Children		
Respite		
Independent Support Broker		

Waiver Service	Employer Authority	Budget Authority
Supported Employment		
Transportation		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

Yes. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

Financial Mangement Services

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Entities providing FMS must be cooperative, not-for-profit member owned and controlled, federally insured financial institution that is and charged by either the National Credit Union Administration or the Credit Union Division of the Iowa Department of Commerce. The FMS must successfully pass a readiness review of certification by HHS or a financial institution charted by the Office if the Comptroller of the Currency, a Bureau of the United States Department of the Treasury, is a member of the Federal Reserve; and/or is federally insured by the Federal Deposit Corporation. Further, the entity must be enrolled as a Medicaid provider. Once enrolled and approved as a Medicaid provider, the FMS will receive Medicaid funds in an electronic transfer and will pay all service providers and employees electing the self-direction option.

MCOs are responsible for contracting with an FMS entity or entities to assist members who elect to self-direct. All MCO contracted FMS entities must meet the requirements documented in this section. Under the managed care delivery system, the FMS entity contracted with the MCO is responsible for the same functions as under the fee-for-service model.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS entities are paid a monthly fee for their services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Iowa Medicaid provides oversight of the FMS entities and monitors their performance yearly. Oversight is conducted through an annual self-assessment, and an on-site review completed by HHS or by a designated Iowa Medicaid unit. As noted above, FMS entities must also be enrolled as Medicaid providers. The MCOs are required to mirror this oversight process for their FMS entities and the Iowa Medicaid reviews for compliance and monitors outcomes.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The case manager or community-based case manager provides the ID waiver member with information and assistance with choosing the CCO program or CDAC service as part of the person centered service planning process. The case manager or community-based case manager also assists the member in locating an Individual Support Broker to assist with the planning and managing a monthly CCO budget and is responsible for monitoring the delivery of goods and services as identified in the service plan.

The CCO program issues informational letters and conducts CCO webinars as needed to provide case managers, community-based case managers and ISB's with information on understanding and implementing the CCO program. The webinars also identify self-direction issues that have been identified through quality assurance activities. All case managers and community-based case managers are welcome to attend the webinars, which are also recorded and made available for those unable to attend.

The CDAC service began in Iowa in 1996 and was the first attempt by the State to offer self-directed services. CDAC is a self-directed service that offers the member employer authority only. There are two CDAC services—skilled and unskilled. See Appendix C for service description and provider qualifications. All CDAC providers are enrolled Medicaid providers, and may be an individual employee or an agency. There are no FMS or ISB services to support the CDAC service, and the enrolled CDAC provider performs all billing through the Medicaid MMIS systems. The member is responsible for completing the CDAC agreement with the CDAC provider. The CDAC agreement identifies the personal care services that will be performed. The member is responsible for hiring, directing, and supervising the CDAC provider to assure their identified needs are being met. Members are also responsible for signing CDAC timecards to allow payment for services.

Waiver Service Coverage.
Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Self Directed Community Support and Employment	
Adult Day Care	
Consumer Directed Attendant Care (CDAC) - unskilled	

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

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Through a contract with the Iowa Medicaid the HCBS Quality Assurance and Technical Assistance Unit provides support and assistance to service workers, case managers, health home coordinators, community-based case managers, members, providers, ISBs, and others needing information about HCBS waiver programs. This includes the self-direction program. The technical assistance provided includes developing and conducting regularly scheduled webinar trainings, developing and implementing required ISB training and answering questions from the field about the CCO program.

The Quality Assurance and Technical Assistance contract is procured through a competitive bidding process. A request for proposal is issued every three years to solicit bids. The RFP specifies the scope of work to be completed by the contractor. The RFP process also includes a pricing component to assure that the contractor is reimbursed in an amount that assures performance outcomes are achieved in a cost-effective manner.

The Quality Assurance and Technical Assistance contract is managed by an Iowa Medicaid state employee. This employee acts as the contract manager and manages the day-to-day operations of the contract to assure compliance with the performance outcomes of the contract. Contract reports are received by the Iowa Medicaid monthly, quarterly and annually on the performance measures of the contract. Any performance issues that arise are addressed with the Quality Assurance and Technical Assistance Unit contract manager to make corrections and improve performance.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Members may receive traditional waiver services, as well as services and supports under an individual budget for self-direction. Any waiver member may voluntarily discontinue the self-direction option at any time, regardless of delivery system (FFS members or MCO members). The member will continue to be eligible for services as specified in the service plan, regardless of whether they select the self-direction option. When CCO is discontinued or the CCO services are voluntarily reduced, a new service plan will be developed to authorize needed services that will be provided through an enrolled ID Waiver provider (vs. the CCO program). The case manager or community-based case manager will work with the member to ensure that a current service plan is authorized, services are in place, and service continuity is maintained.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily

terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

For fee-for-service members, HHS service case managers will terminate use of the self-direction option any time there is substantial evidence of Medicaid fraud or obvious misuse of funds. Involuntary termination can also occur if the case manager is not able to verify the types of services provided and the outcome of those services. If the member and their representative are both found unable to self-direct, the member will be transitioned to regular waiver services. The member has the right to appeal any adverse action taken by the case manager to terminate self-directed services and is subject to the grievance and appeals protections outlined in Appendix F. The case manager will develop a new service plan and assure alternative services are in place to maintain service.

For MCO members, a community-based case managers will terminate use of the self-direction option any time there is substantial evidence of Medicaid fraud or obvious misuse of funds. Involuntary termination can also occur if the community-based case manager is not able to verify the types of services provided and the outcome of those services. If the member and their representative are both found unable to self-direct, the member will be transitioned to regular waiver services. The member has the right to appeal any adverse action taken by the community-based case manager to terminate self-directed services and is subject to the grievance and appeals protections outlined in Appendix F. The community-based case manager will develop a new service plan and assure alternative services are in place to maintain service.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		2600
Year 2		2600
Year 3		2600
Year 4		2600
Year 5		2600

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Pursuant to Iowa Code 249A.29 and Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), all providers of HCBS waiver services must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff who will provide care for a member. The State pays for the first background check of workers who provide waiver services to fee-for-service members. If a second background check is completed, it is the responsibility of the employee to pay for the background check. MCOs are responsible for the costs of investigations of workers who provide waiver services to members.

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Same as C-2-a above.

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Under the traditional service model for the ID waiver, the member chooses a service provider from a list of providers who are enrolled with Iowa Medicaid. The case manager or community based case manager and the member work together develop and authorize the needed services in the member's service plan. After service provision, the provider submits a claim to the Iowa Medicaid where the claim is adjudicated in accordance with Iowa Medicaid protocols.

Under the self-direction option, a member is not limited to the providers who are enrolled with Iowa Medicaid. The member is considered the employer and may choose any employee or community based business that is qualified to provide the needed service. Members create a self-directed budget to identify provider and service choices to meet their identified needs. Members determine the wages to be paid to the employee and the units of service (limited by the self-direction budget). Employee interviewing, hiring, scheduling, and firing are done by the member. Claims are submitted to the FMS for processing and payment.

Each member who chooses to self-direct their services will continue to have a traditional service plan developed that is based on the core standardized assessment and service needs of the member. If a member is authorized for services that can be included in the individual budget and they choose self-direction, the individual budget amount is determined by the amount and type of service that was authorized in the traditional service plan. The amount and type of services needed are determined through the person centered planning process and authorized in the member's service plan by the case manager or community based case manager prior to the member selecting the self-direction option.
To determine a member's CCO budget amount, the department determines the average unit cost for each service available for use in CCO based on actual unit costs of the service as billed by the enrolled Medicaid providers from the previous fiscal year plus a cost-of-living adjustment. In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department applies a utilization adjustment factor to the amount of service authorized in the member's service plan. The department computes the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent.
The individual budget rate setting methodology is stated in the 441 Iowa Administrative Code Chapter 78.41(15). In addition this information is shared during all outreach and training held throughout the State for members, families, and other advocates. The MCOs are also responsible for making the budget methodology available to members through their case managers and member communication materials.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Members, regardless of delivery system (i.e., FFS members and MCO members) will be informed of their budget amount during the development of the service plan. The budget amount is based on the amount and type of services that are converted from the member's authorized service plan. The member can then make a final decision as to whether they want the self-direction option. If a member needs an adjustment to the budget, the member can:

• Request the case manager or community based case manager to review of the current authorized service plan to identify if an increase in services is needed.
• If there is a need that goes beyond the budget amount and/or the waiver service limit, the member has the right to request an exception to policy to allow additional CCO funds be made available to the member. Approval of an exception to policy requires the review and sign off of the Director of the Department of Health and Human Services.

Any member has the right to appeal any adverse action taken. The member is afforded the opportunity to request a fair hearing when the increased service request is denied or the amount of budget is reduced as described in F-1. MCO enrollees have the right to a State Fair Hearing after exhausting the MCO appeals process. It is the responsibility of the case manager or community case manager to inform the member of the budget amount allowed for services before the service plan is completed.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

For both fee-for-service and MCO members, once the monthly budget amount has been established, the member will develop a detailed monthly budget that identifies the goods and services that will be purchased and the employees that will be hired to meet the assessed needs of the member. The budget is sent to the FMS to identify what goods and services are approved for purchase and the employees that will be submitting timecards to the FMS for payment. The member can modify services and adjust dollar amounts among line items in the individual budget without changing the member's authorized service plan as long as it does not exceed the authorized budget amount. Current monthly expenditures must also be taken into consideration when adjusting the CCO budget mid-month. The member must submit a new budget to the FMS that identifies the changes. The FMS must receive all modifications to the individual budget within the month when the changes occur and will monitor the new budget to assure the changes do not exceed the authorized budget amount. The Individual Support Broker and the FMS will both monitor to assure expenses are allowable expenses.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be

associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

When members chose self-direction they sign a consent form that explains their rights and responsibilities, including consequences for authorizing payments over the authorized budget amount.

Members are responsible to monitor their own plans, and are responsible for the consequences. One of the statements from Form 470-4289 Informed Consent and Risk Agreement states: "I understand that if I overspend my budget and no longer have funds in my Individual budget, I am personally responsible to pay my employees and to pay for my purchases."

Self-directed service utilization is monitored by the member's case manager or community based case manager quarterly to assure it continues to meet the needs of the member. At least annually and or more frequently as needed by the member. An annual service plan review is conducted to review all services that were authorized in the previous year to assure they require continued authorization. The case manager or community based case manager has access to self-directed service utilization of the member in the previous year and may reduce the amount of services if it is determined that the member was not fully using the services as authorized.

The following safeguards are in place to prevent premature depletion of participant budget:
• The case manager and member or legal representative work together to create a service plan addressing person centered needs.
• The member selects services to be self-directed. This information is included in the service plan.
• The case manager authorizes services in the service plan.
• The member or legal representative the signs service plan to indicate agreement with the plan.
• The case manager identifies the CCO budget amount and provides the amount to the member or legal representative and Independent Support Broker (ISB).
• The member and the ISB complete the CCO budget on the budget sheet, form 470-4431. The budget amount on the budget sheet cannot exceed the amount
approved by the case manager in the service plan
• The member or legal representative signs the budget sheet to indicate understanding and agreement.
• The budget sheet is forwarded to the FMS prior to the month of service identified on the budget.
• The FMS staffs a call center to respond timely to member, legal representative and ISB questions about processes and remaining budget balances.
• The FMS verifies that the amount included on the budget form does not exceed the authorized budget amount.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Application Process for both FFS and MCO enrolled members:

Members are given an oral explanation of the appeals (State Fair Hearing) process during the application process by the Iowa Department of Health and Human Services (HHS) income maintenance staff. The responsibility to explain the right to request a State Fair Hearing for choice between institutional care vs. HCBS is the responsibility of the state's Income Maintenance worker at the time of waiver application; this action is not the responsibility of the MCO.

The Department also gives members an oral explanation at the time of any contemplated adverse benefit determination. Depending on the adverse benefit determination, this could be provided by the income maintenance worker, case manager, community-based case manager, medical provider performing the level of care determination. The member is also given written notice of the following at the time of application and at the time of any department adverse benefit determination. An adverse benefit determination affects a claim for assistance in which applicants are not provided the choice of home and community based services as an alternative to institutional care and members are denied services or providers of their choice, or whose services are denied, suspended, reduced or terminated.

An adverse benefit determination notice of determination that results in members' right to appeal includes the following elements: the right to request a hearing, the procedure for requesting a hearing, the right to be represented by others at the hearing, unless otherwise specified by the statute or federal regulation, provisions for payment of legal fees by HHS; and how to obtain assistance, including the right to continue services while an appeal is pending.

All HHS application forms, notices, pamphlets and brochures contain information on the appeals process and the opportunity to request an appeal. This information is available at all of the local offices and on the HHS website. The process for filing an appeal can be found on all Notices of Decision (NOD). Procedures regarding the appeal hearing can be found on the NOD. As stated in Iowa Administrative Code, any person or group of persons may file an appeal with HHS concerning any decision, made. The member is encouraged, but not required, to make a written appeal on a standard Appeal and Request a Hearing form. Appeals may also be filed via the HHS website. If the member is unwilling to complete the form, the member would need to request the appeal in writing.

All notices are kept at all local HHS Offices or the case manager or community-based case manager's file. The member is given their appeal rights in writing, which explains their right to continue with their current services while the appeal is under consideration. Copies of all notices for a change in service are maintained in the service file. Iowa Medicaid reviews this information during case reviews.

MANAGED CARE ORGANIZATIONS:
When an HCBS member is assigned to a specific MCO, the assigned MCO community based case manager explains the member's appeal rights through the Fair Hearing process during the initial intake process. The responsibility to explain the right to request a State Fair Hearing for choice between institutional care vs. HCBS is the responsibility of the state's Income Maintenance worker at the time of waiver application; this action is not the responsibility of the MCO.

The MCOs keep the notifications as indicated here:
Amerigroup: Notices are sent to requesting provider, member, and a copy is stored in online member medical record file.
UnitedHealthCare: Notices of adverse action (which outline a member's rights to Fair Hearing) are housed within specified documentation storage systems based on service/case type. These systems include: Linx, ECAA, and ETS.

In accordance with 42 CFR 438, an adverse benefit determination means any of the following:
(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
(2) The reduction, suspension, or termination of a previously authorized service.
(3) The denial, in whole or in part, of payment for a service.
(4) The failure to provide services in a timely manner, as defined by the State.
(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

In accordance with 42 CFR 438, an appeal means a review by an MCO of an adverse benefit determination that it has issued.

MCOs give their members written notice of all adverse benefit determinations, not only service authorization adverse benefit determinations, in accordance with state and federal rules, regulations and policies, including but not limited to 42 CFR 438. MCO enrollment materials must contain all information for appeals rights as delineated in 42 CFR 438.10, including: (A) the right to file an appeal; (B) requirements and timeframes for filing an appeal; (C) the availability of assistance in the filing process; (D) the right to request a State Fair Hearing after the MCO has made a determination of a member's internal MCO appeal which is adverse to the member. The fact that, if requested by the member, benefits that the MCO seeks to reduce or terminate will continue if the member files an appeal or requests a State fair hearing within the specified timeframe and that the member may be required to pay the cost of such services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the member.

MCOs must provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to providing interpreter services, and toll-free numbers that have adequate TTY/TTD and interpreter capability. Upon determination of the appeal, the MCO must ensure there is no delay in notification or mailing to the member and member representative the appeal decision. The MCO's appeal decision notice must describe the adverse benefit determinations taken, the reasons for the adverse benefit determination, the member's right to request a State fair hearing, process for filing a fair hearing and other information set forth in 42 CFR 438.408(e).

MCOs must maintain an expedited appeals process when the standard time for appeal could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain or regain maximum function. The MCO must also provide general and targeted education to members and providers regarding expedited appeals including when an expedited appeal is appropriate and procedures for providing written certification thereof.

The MCO's appeal process must conform to the following requirements:

– Allow members, or providers acting on the member's behalf, sixty (60) calendar days from the date of adverse benefit determination notice within which to file an appeal.
– In accordance with 42 CFR 438.402, ensure that oral requests seeking to appeal an adverse benefit determination are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.
– The MCO must dispose of expedited appeals within 72 hours after the Contractor receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c).
– In accordance with 42 CFR 438.410, if the MCO denies the request for an expedited resolution of a member's appeal, the MCO must transfer the appeal to the standard thirty (30) calendar day timeframe and give the member written notice of the denial within two (2) calendar days of the expedited appeal request. The MCO must also make a reasonable attempt to give the member prompt oral notice.
– The MCO must acknowledge receipt of each standard appeal within three (3) business days.
– The MCO must make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 CFR 438.408. If the timeframe is extended, for any extension not requested by the member, the MCO must give the member written notice of the reason for the delay.
– In accordance with 42 CFR 438.408, written notice of appeal disposition must be provided with citation of the Iowa Code and/or Iowa Administrative Code sections supporting the adverse benefit determination in non-authorization and care review letters that advise members of the right to appeal. For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice. The written notice of the resolution must include the results of the resolution and the date it was completed. For appeals not resolved wholly in favor of the member, the written notice must include the right to request a State fair hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. The MCO shall direct the member to the Agency Appeal and Request for Hearing form as an option for submitting a request for an appeal. This shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds the Contractor's adverse benefit determination.

Members enrolled with an MCO must exhaust the MCO's internal grievance processes before pursuing a State Fair Hearing. This requirement is outlined in the concurrent §1915(b) waiver, Part IV, Section E.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Each MCO operates its own internal grievance and dispute resolution processes. In accordance to 42 CFR 438.408(f), a managed care enrollee may request a State Fair Hearing only after receiving notice that the MCO is upholding the adverse benefit determination.

The policies and procedures regarding the MCO grievance and appeals system are outlined in the concurrent §1915(b) waiver, Part IV, Section E. MCO members can appeal any adverse benefit determination within 60 calendar days. An adverse benefit determination is defined as the:
(i) denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
(ii) reduction, suspension or termination of a previously authorized service;
(iii) denial, in whole or in part, of payment for a service;
(iv) failure to provide services in a timely manner;
(v) failure of the MCO to act within the required timeframes; or
(vi) the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

MCOs must ensure that oral requests seeking to appeal an adverse benefit determination are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution. MCOs must make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 C.F.R. § 438.408. Expedited appeals must be disposed within seventy-two (72) hours unless the timeframe is extended pursuant to 42 CFR § 438.408 and 410. MCO members can also file grievances with their MCO; grievances are any written or verbal expression of dissatisfaction about any matter other than an adverse benefit determination." MCO members have the right to request a State Fair Hearing if dissatisfied with the outcome of the MCO appeals process. MCOs notify members of this right through enrollment materials and notices of adverse benefit determination, including information that the MCO grievance and appeals process is not a substitute for a Fair Hearing. MCOs must acknowledge receipt of a grievance within three (3) business days and must make a decision on grievances and provide written notice of the disposition of grievance within thirty (30) calendar days of receipt of the grievance or as expeditiously as the member's health condition requires. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 C.F.R. § 438.408.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

FEE FOR SERVICE:

Iowa Medicaid is responsible for operation of the complaint and grievance reporting process for all fee-for-service members. In addition, the Department maintains an HCBS Quality Oversight Unit contract that is responsible for the handling of fee-for-service member complaints and grievances in regards to provision of services under this waiver.

MANAGED CARE ORGANIZATION:

Iowa Medicaid Member Services MCO Member and MCO Liaison: Designated Iowa Medicaid Member Services staff serves as a liaison for any MCO grievance/complaint that is reported to Iowa Medicaid Policy staff by an MCO member or his/her advocate. Iowa Medicaid Policy sends the pertinent details of the grievance/complaint to the MCO liaison. The Iowa Medicaid MCO liaison communicates and coordinates with the MCO and member to grievance/complaint to resolution; and, the resolution is communicated to the Iowa Medicaid Policy staff who received the original grievance/complaint. This process serves to support those MCO members who may be confused about the MCO grievance/complaint process to follow or members who have not been able to resolve their grievance/complaint with their MCOs.

Grievances/complaints follow the parameters and timelines in accordance with 42 CFR 438.408 and 438.410.

A grievance/complaint means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision.

MCO Grievance/Complaint System:
The MCO must provide information about its grievance/complaint system to all providers and subcontractors at the time they enter into a contract. Further, the MCO is responsible for maintenance of grievance records in accordance with 42 CFR 438.416.

The MCO must provide information about its grievance/complaint system to all members and provide reasonable assistance in completing forms and taking procedural steps. This responsibility also includes; but is not limited to, auxiliary aids and services upon request (e.g. interpreter services and toll free numbers that have TTY/TTD and interpreter capability).

The MCO member handbook must include information, consistent with 42 CFR 38.10.

The MCO must insure that individuals who make decisions on grievances have not been involved in any previous level of review or decision-making and is not a subordinate of such individual.

MCO Grievance/Complaint Process:
A member may submit an oral or written grievance at any time to the MCO. With written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. There is not a timeline for submission.

The MCO must acknowledge receipt of the grievance.

The MCO must process the grievance resolution within 30 days of the date that the grievance is received and issue a written notification to the member in accordance with 42 CFR 438.408.

The resolution may be extended by fourteen (14) days upon member request. If the member does not request an extension, the MCO must make reasonable efforts to give the member prompt oral notice of the delay; and within two (2) calendar days provide the member with a written notice of the basis for the decision to extend the timeframe. If the member does not agree with the extension, he/she may file an additional grievance to the extension.

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that

are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Any fee-for-service waiver member, member's relative/guardian, agency staff, concerned citizen or other public agency staff may report a complaint regarding the care, treatment, and services provided to a member. A complaint may be submitted in writing, in person, by e-mail or by telephone. Verbal reports may require submission of a detailed written report. The complaint may be submitted to an HCBS Provider Quality Oversight Specialist, HCBS Program Manager, any Iowa Medicaid Unit, or Bureau Chief of Long Term Care. Complaints by phone can be made to a regional HCBS Provider Quality Assurance Oversight Specialist at their local number or by calling the Iowa Medicaid. The Bureau of Long Term Care has established a committee to review complaints. The committee will meet biweekly to review current complaints.

Once received, the HCBS Quality Oversight Unit shall initiate investigation within one business day of receipt and shall submit a findings report to the Quality Assurance Manager within 15 days of finalizing the investigation. Once approved by the Quality Assurance Manager, the findings report is provided to the complainant and the provider in question. If the complainant is a member, they are informed by the HCBS Quality Oversight Unit Incident and Complaint Specialist that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing.

MCO members must exhaust the entity's internal grievance and appeals processes before pursuing a State Fair Hearing. The policies and procedures regarding the MCO grievance and appeals system are outlined in the concurrent §1915(b) waiver, Part IV, Section E. MCO members can appeal any "action" within 60 days. An "action" is defined as the: (i) denial or limited authorization of a requested service, including the type or level of service; (ii) reduction, suspension or termination of a previously authorized service; (iii) denial, in whole or in part, of payment for a service; (iv) failure to provide services in a timely manner; or (v) failure of the MCO to act within the required timeframes set forth in 42 CFR 438.408(b). In accordance with 42 CFR 438.406, oral requests seeking an appeal are treated by the MCO as an appeal; however, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.

MCO members have the right to request a State Fair Hearing if dissatisfied with the outcome of the MCO appeals process. MCOs notify members of this right through enrollment materials and notices of action. In accordance with 42 CFR 438.406, the MCO provides the member and their representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents or records considered during the appeals process. In addition, the member and their representative have the opportunity to present evidence and allegations of fact or law in person as well as in writing. Upon determination of the appeal, the MCO must promptly notify the member and his/her representative of the appeal decision. The MCO's appeal decision notice must describe the actions taken, the reasons for the action, the member's right to request a State Fair Hearing, process for filing a Fair Hearing and other information set forth in 42 CFR 438.408(e).

MCOs must ensure that the individuals rendering decisions on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with appropriate clinical expertise in treating the member's condition or disease if the decision will be in regard to any of the following: (i) an appeal of a denial based on lack of medical necessity; (ii) a grievance regarding denial of expedited resolution of an appeal; or (iii) any grievance or appeal involving clinical issues. Appeals must be resolved by the MCO within 30 calendar days of receipt; this timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c).

MCOs must resolve appeals on an expedited basis when the standard time for appeal could seriously jeopardize the member's health or ability to maintain or regain maximum function. Such expedited appeals must be resolved within 72 hours after the MCO receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c). Standard appeals must be resolved within 30 calendar days; this timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c). If the timeframe is extended, for any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay. Within 90 calendar days of the date of notice from the MCO on the appeal decision, the member may request a State Fair Hearing.

MCO members can also file grievances with their MCO; grievances are any written or verbal expression of dissatisfaction about any matter other than an "action," as defined above. Grievances may be filed either orally or in writing; receipt is acknowledged by the MCO within 3 business days and resolved within 30 calendar days or as expeditiously as the member's health condition requires. This timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c).

MCOs are required to track all grievances and appeals in their information systems; this includes data on clinical reviews,

appeals, grievances and complaints and their outcomes. MCOs are responsible for reporting on grievances and appeals to HHS. This includes maintenance and reporting to the State the MCO member grievance and appeals logs which includes the current status of all grievances and appeals and processing timelines.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process *(complete Items b through e)*

No. This Appendix does not apply *(do not complete Items b through e)*
If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All waiver service providers, case managers, and MCO community based case managers (CBCMs), regardless of delivery system (i.e., FFS or managed care), are required to document major and minor incidents and make the incident reports and related documentation available to HHS upon request. Providers, case managers, and MCO CBCMs must also ensure cooperation in providing pertinent information regarding incidents as requested by HHS. MCOs must require that all internal staff and network providers report, respond to, and document major incidents, as well as cooperate with any investigation conducted by the MCO or outside agency, all in accordance with State requirements for reporting incidents for 1915(c) HCBS Waivers, 1915(i) Habilitation Program, PMICs, and all other incidents required for licensure of programs through the Department of Inspections and Appeals.

Major incident is defined as an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and that:
• results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital,
• results in the death of the member, including those resulting from known and unknown medical conditions,
• results in emergency mental health treatment for the member, (EMS, Crisis Response, ER visit, Hospitalization)
• results in medical treatment for the member, (EMS, ER Visit, Hospitalization)
• results in the intervention of law enforcement, including contacts, arrests, and incarcerations,
• results in a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3,
• constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in bullets 1, 2, 3, 4, 5, and 6 above
• involves a member's provider staff, who are assigned protective oversight, being unable to locate the member or
• involves a member leaving the program against court orders, or professional advice
• involves the use of physical or chemical restraint or seclusion of the member

All major incidents must be reported by the end of the next calendar day using the Iowa Medicaid's Iowa Medicaid Portal Access (IMPA) System. Suspected abuse or neglect may be reported to the statewide abuse reporting hotline operated by HHS.

Child and dependent adult abuse is an inclusive definition that includes physical and sexual abuse, neglect and exploitation. Child abuse is defined in Iowa Code 232.68, and may include any of the following types of acts of willful or negligent acts or omissions:
- Any non-accidental physical injury.
- Any mental injury to a child's intellectual or psychological capacity.
- Commission of a sexual offense with or to a child.
- Failure on the part of a person responsible for the care of a child to provide adequate food, shelter, clothing or other care necessary for the child's health and welfare.
-The acts or omissions of a person responsible for the care of a child which allow, permit, or encourage the child to engage in prostitution.
- Presence of an illegal drug in a child's body as a direct act or omission of the person responsible for the care of a child or is using, manufacturing, cultivating, or distributing a dangerous substance in the presence of a child.
-The commission of bestiality in the presence of a minor.
-A person who is responsible for the care of a child knowingly allowing another person custody of, control over, or unsupervised access to a child under the age of fourteen or a child with a physical or mental disability, after knowing the other person is required to register or is on the sex offender registry.
-The person responsible for the care of the child has knowingly allowed the child access to obscene material or has knowingly disseminated or exhibited such material to the child.
-The recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a child for the purpose of commercial sexual activity.

Dependent adult abuse is defined in Iowa Code 235B.2, and may include any of the following types of acts of willful or negligent acts or omissions:
- Physical injury or unreasonable confinement, unreasonable punishment, or assault of a dependent adult.
- Commission of a sexual offense or sexual exploitation.
- Exploitation of a dependent adult which means the act or process of taking unfair advantage of a dependent adult or the adult's physical or financial resources, without the informed consent of the dependent adult, including theft, by the use of undue influence, harassment, duress, deception, false representation, or false pretenses.

- Deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care or other care necessary to maintain a dependent adult's life or health.
-Personal degradation of a dependent adult by a caretaker. "Personal degradation" means a willful act or statement by a caretaker intended to shame, degrade, humiliate, or otherwise harm the personal dignity of a dependent adult, or where the caretaker knew or reasonably should have known the act or statement would cause shame, degradation, humiliation, or harm to the personal dignity of a reasonable person.

When a major incident occurs, provider staff must notify the member or the member's legal guardian by the end of the next calendar day of the incident and distribute a completed incident report form as follows:
- Forward a copy to the supervisor with by the end of the next calendar day of the incident.
- Send a copy of the report to the member's case manager and the Iowa Medicaid by the end of the next calendar day of the incident.
- File a copy of the report in a centralized location and make a notation in the member's file.

Per Chapter 441 Iowa Administrative Code 77.25(1), "minor incidents" are defined as an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and that is not a major incident and that:
(1) results in the application of basic first aid;
(2) results in bruising;
(3) results in seizure activity;
(4) results in injury to self, to others, or to property; or
(5) constitutes a prescription medication error.

Providers are not required to report minor incidents to the Iowa Medicaid or MCO, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the member's file. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs, or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the member's file.

As part of the quality assurance policies and procedures for HCBS Waivers, all major incidents will be monitored and remediated by the HCBS Incident Reporting Specialist and HCBS specialists. On a quarterly basis, the Quality Assurance (QA) committee will review data collected on incidents and will analyze data to determine trends, problems and issues in service delivery and make recommendations of any policy changes.

MCOs are also required to develop and implement a major incident management system in accordance with HHS requirements, in addition to maintaining policies and procedures that address and respond to incidents, remediate the incidents to the individual level, report incidents to the appropriate entities per required timeframes, and track and analyze incidents.

MCOs must adhere to the State's quality improvement strategy described in each HCBS waiver and waiver-specific methods for discovery and remediation. MCOs must utilize system information to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. All MCO staff and network providers are required to:

- Report major incidents.
- Respond to major incidents.
- Document major incidents.
- Cooperate with any investigation conducted by the HCBS Quality Assurance and Technical Assistance Unit staff, MCO, or outside agency.
- Receive and provide training on major incident policies and procedures.
- Be subject to corrective action as needed to ensure provider compliance with major incident requirements.

Finally, MCOs must identify and track major incidents, and review and analyze major incidents, to identify and address quality of care and/or health and safety issues, including a regular review of the number and types of incidents and findings from investigations. This data should be used to develop strategies to reduce the occurrence of major incidents and improve the quality of care delivered to members.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information concerning protections from abuse, neglect, and exploitation is provided to applicants and members at the time of application and at the time of service plan development. During enrollment, and when any updates are made, HHS also provides to members a Medicaid Members Handbook, which contains information regarding filing a complaint or grievance. MCO written member enrollment materials also contain information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect.

In addition, information can also be found on HHS and MCO websites. The HHS website contains a “Report Abuse and Fraud” section, which describes how to report dependent adult child abuse. The same information is also available in written format in the 99 local HHS offices, and members may also call the Iowa Medicaid Member Services call center with any questions regarding filing a complaint or grievance.

Finally, the case manager or community-based case manager is responsible for assessing a member’s risk factors annually during the reevaluation process, as well as during the quality assurance interview process and the annual CAHPS interview. HHS recognizes the need to provide training to members using on a more formal process. The state has developed training to ensure that case managers and community-based case managers provide this information to members at a minimum on a yearly basis.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Reporting of suspected child or adult abuse to HHS Protective Services is mandatory for all Iowa Medicaid HCBS staff, case managers, MCO CBCMs, and HCBS providers. HHS Protective Services (PS) receives all mandatory reports of child and dependent adult abuse. If an immediate threat of physical safety is believed to exist, PS makes every effort to examine that child or dependent adult within one hour of receipt and take any lawful action necessary. If the child or dependent adult is not in danger, PS makes every effort to examine the child or dependent adult within 24 hours. PS notifies the member's case manager or community-based case manager when an investigation has been initiated to ensure they are aware of the alleged abuse, and to ensure that additional services can be added or changes can be made to the member's plan of care if needed. PS provides an evaluation report within twenty days of receipt of the report of abuse, which includes necessary actions and/or an assessment of services needed. The Central Registry of Abuse and County Attorney also receives PS reports. For both child and dependent adult abuse cases, the member and/or the family are notified of the results in writing by HHS as soon as the investigation has concluded. This applies to both individuals enrolled in fee-for-service or managed care.

If the incident is a situation that has caused, or is likely to cause a serious injury, impairment, or abuse to the member, and if PS has completed, or is in the process of conducting an investigation, the HCBS Specialist (employed by the Iowa Medicaid HCBS Quality Oversight contractor) coordinates activities with PS to ensure the safety of the member is addressed. If PS is not investigating and immediate jeopardy remains, the member's case manager or community-based case manager is notified immediately to coordinate services, and the HCBS Specialist initiates a review within two working days of receipt of the report. If it is determined that immediate jeopardy has been removed or not present, review by the HCBS Specialist is initiated within twenty working days of receipt of report. The HCBS Specialist prepares a report of findings within thirty days of the investigation being completed and presents it to the Iowa Medicaid, the provider, and interested stakeholders (i.e., members, guardians, etc.). These timelines apply to both individuals enrolled in fee-for-service or managed care.

The HCBS incident and complaint specialists refers any untimely, incomplete, or inaccurate CIR or CIR missing root cause, immediate resolution or long-term remediation to the reporter or the reporter's supervisor as applicable. A pattern or trend of issues, inappropriate or ineffective root causes, immediate resolutions, or long-term remediations may require follow-up technical assistance with the reporter or reporter's supervisor, as applicable. Patterns to look for include but are not limited to:

*Patterns in the timing of incidents (i.e., at transition times, evenings, mornings, when the member is unsupervised, mealtimes.)
*Patterns in root cause- events leading up to the incident or that may have caused the incident.
*Patterns in the type of incident or issue.
*Patterns in staff or others involved.

Technical assistance may be provided by the HCBS incident and complaint specialist or a regional HCBS specialist.

The Iowa Medicaid meets bi-weekly to review major incident reports of child and dependent adult abuse and member deaths that have been reported through the major incident reporting process. HHS reviews and requests information from the case manager, community-based case manager or HCBS Specialist for follow through and resolution of the abuse allegation and member deaths. Requests for information are forwarded to the case manager or community-based case manager to verify any needed changes and confirm that follow-up has occurred with the member (i.e., changes to a plan of care or the safety or risk plan as necessary). If additional information or actions are required of a provider, the HCBS Specialist works directly with the provider to ensure that performance issues identified in the incident report are addressed. The HCBS Specialist uses the provider's Self-Assessment as the foundation of the review to assure that accuracy in the Self-Assessment and to identify any corrective actions that may be required. The HCBS Specialist generates a report of findings within thirty days of the completion of any review requiring corrective actions.

Information requests to the case manager, community-based case manager or HCBS Specialist for follow up are tracked by the HCBS Quality Oversight Unit on a weekly basis until the situation has been resolved. HHS implemented a web-based major incident reporting system September 1, 2009, that significantly enhanced the State's ability to track and trend the discovery, remediation, and improvement of the major incident reporting process. Revisions have been made to the system based on data collection and feedback from users, further enhancing the process. Incidents are reviewed by the HCBS Quality Oversight Unit within one business day of report and forwarded to the case manager or community-based case manager as needed to coordinate any follow-up and communication with the member, provider, and/or family/legal guardian. Incidents that lead to a targeted review will initiate investigation by the HCBS Quality Oversight

Unit within one business day. Findings reports are submitted to the Quality Assurance Manager within 15 days of investigation completion. Once the finding report is approved by the Quality Assurance Manager, the findings report is sent to the provider and case manager, community-based case manager, or HCBS Specialist.

MCOs are responsible for developing and implementing major incident management systems in accordance with the HHS requirements identified in Appendix G-1-b. Specifically, MCOs must maintain policies and procedures, subject to HHS review and approval, that:
(1) address and respond to incidents;
(2) report incidents to the appropriate entities per required timeframes; and
(3) track and analyze incidents.
This information is utilized to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. Training must be provided to all internal staff and network providers regarding the appropriate procedures for reporting, responding to, and documenting major incidents. Network providers must provide training to direct care staff regarding the appropriate procedures for reporting, responding to, and documenting major incidents.

Finally, if the major incident involves the report of child or dependent adult abuse, it is mandatory that this type of major incident is reported to HHS Protective Services. If the major incident does not involve child or dependent adult abuse, it will be reviewed by the MCO. The MCO will notify the member and/or the family of the results upon conclusion of the investigation, on or within 30 days.

MCOs must identify and track, review and analyze major incidents to identify and address quality of care and/or health and safety issues. MCOs must also regularly review the number and types of incidents and findings from investigations, in order to identify trends, patterns, and areas for improvement. Based on these findings, the MCO must develop and implement strategies to reduce the occurrence of major incidents and improve the quality of care delivered to members.
Consistent with 441 Iowa Administrative Code 77.25 (3), the following process is followed when a major incident occurs or a staff member becomes aware of a major incident:
(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
a. The staff member's supervisor.
b. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the
provider's service provision. Notification to a guardian, if any, is always required.
c. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization or for members not enrolled with a MCO, the department's bureau of long-term care either:
a. By direct data entry into the Iowa Medicaid Provider Access System, or
b. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

a. The name of the member involved.
b. The date and time the incident occurred.
c. A description of the incident.
d. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The
confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.
e. The action that the provider staff took to manage the incident.
f. The resolution of or follow-up to the incident.
g. The date the report is made and the handwritten or electronic signature of the person making the report.

If the critical incident involves the report of child or dependent adult abuse, it is mandatory that this type of critical incident is reported to HHS Protective Services.

If the critical incident does not involve child or dependent adult abuse, it will be reviewed by the MCO. The MCO will notify the member and/or the family of the results upon conclusion of the investigation, on or within 30 days.

If the member is not with an MCO, the FFS case manager will notify the member, guardian, and or legal representative, verbally or in writing, of the results upon conclusion of the investigation, on or within 30 days.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Iowa Medicaid has oversight for monitoring incidents that affect all waiver members. The Iowa Medicaid HCBS Quality Oversight Unit reviews all critical incident reports as soon as they are reported to HHS. All critical incidents are tracked in a critical incident database that tracks the date of the event, the specific waiver the member is enrolled in, the provider (if applicable), and the nature of the event, and follow up provided. For other non-jeopardy incidents, a review is initiated within twenty days. The HCBS Quality Assurance and Technical Assistance Unit meets biweekly to review data tracked in the critical incident database and to decide if policy changes or additional training are needed. Data is compiled and analyzed in attempt to prevent future incidents through identification of system and provider specific training needs, and individual service plan revisions.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The HHS policy regarding restraints is as follows, and applies to all types of restraints that may be used by waiver providers. The policy described in this section applies regardless of delivery system (i.e., FFS participants or MCO members), and MCOs are contractually obligated to adhere.

Restraints include, but are not limited to, personal, chemical, and mechanical methods used for the purpose of controlling the free movement of an member's body. Chemical restraints are most commonly used to calm a member down in moments of escalation. Other examples of restraints include, but are not limited to, holding a member down with one's hands, tying a member to a bed, using a straight jacket or demobilizing wrap. As a rights limitation, the restraint procedures must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of restraints must be documented in a member's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

-The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
-Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
-Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
-Restraint, restriction, and behavioral intervention programs shall be time-limited (maximum one year) and shall be reviewed at least quarterly.
-Corporal punishment and verbal or physical abuse are prohibited."

These safeguards are the same regardless of the type of restraint used. All restraints must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with HHS to provide ID waiver services must conduct its activities in accordance with these requirements. Restraint procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

Physical and chemical restraints may be allowed depending on the provider's agency policy to ensure that there is an accompanying behavioral intervention plan, documentation of each instance, and monitoring of its use. These types of restraints must be considered on an individual basis after the interdisciplinary team reviews, and enters into the restraint in the written plan of care. If a member is placed in a closed room, the time frame must be determined on an individual basis and spelled out in the member's service plan. The provider must document the use of this restraint in the member's service file each time it was utilized by staff. The provider is required to have a written policy approved by HHS on the supervision and monitoring of members placed in a closed room, e.g., monitoring on a fifteen minute basis to assure the health and welfare of the participant.

Restraint procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:

- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of restraints and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Restraints and behavioral interventions may only be utilized to teach replacement behaviors when non-

aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an restraint procedure must be able to carry out the procedure as it is written. Staff must be trained and exhibit proficiency as described below before administering restraints. A staff's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met:
  (i) the supervisor's ability to implement the procedure has been documented by a program staff person;
  (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and
  (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The
  list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
-Implementation of a program to alter an individual's behaviors.

Restraints and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter an member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements.

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the member's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the member and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:

- A Restraint and Behavioral Intervention Program that is a part of the written individual service plan developed by the member's case manager or community-based case manager, and in the provider plan of care developed for the member.
- Approval by the individual's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian, if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the person's health.
- A functional analysis that is defined as and includes the following components:
  (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;
  (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that
  the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;
  (iii) description of the conditions that precede the behavior in question;

(iv) description of what appears to reinforce and maintain the behavior; and
(v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Restraints must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All restraints are explained to the member and their legal representative and agreed upon ahead of time.

Unauthorized use of restraints would be detected via interviews with the member, their family and staff and case manager or community-based case manager; through review of critical incident reports by HHS and member’s case manager or community-based case manager on a daily basis; HHS and case manager or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints). Reviews may include desk reviews where the department requests member’s records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the HHS policy for each type of agency identified restraint is observed and member rights are safeguarded. If it is found that a waiver provider is not observing HHS policy or ensuring a member’s rights, adverse action is taken by the Iowa Medicaid, which may include sanction, required corrective action, termination, etc.

The member’s case manager or community-based case manager is responsible to monitor individual plans of care including the use of restraints and behavioral interventions.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The first line of responsibility for overseeing the use of restraints and ensuring safeguards are in place is the member's case manager or community based case manager. The use of restraints must be assessed as needed and identified in the member's service plan. The use of restraints would also require the development and implementation of a behavior plan and the plan would be included in the member's service plan. The case manager or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restraints would be addressed with the provider of service and corrected as needed.

The State also contracts with the HCBS Quality Oversight Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restraints. The Quality Oversight Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and Federal rules, regulations, and best practices. Further, the Quality Oversight Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether restraints are appropriately incorporated into the service plan, such that restraints are only implemented as designated in the plan (who, what, when, where, why, and how). If the Quality Oversight Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations may be made to Iowa Medicaid Program Integrity Unit for possible provider sanctions (suspension, probation, termination, etc.).

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of restraints. These reports are entered into IMPA, trigger milestones in IoWANS for fee-for-service participants that alert case managers and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Quality Oversight Unit for a targeted review. If the Quality Oversight Unit discovers that the provider is less than compliant in areas surrounding the use of restraints, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations may be made to Iowa Medicaid Program Integrity Unit for possible provider sanctions (suspension, probation, termination, etc.).

The HCBS Quality Oversight Unit is also responsible for conducting the HCBS CAHPS survey with waiver participants. The HCBS Quality Oversight Unit conduct interviews either face-to-face or via telephone, to the discretion of the member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis. The HCBS Specialists conducting CAHPS interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. MCO are responsible for research and follow up to flagged responses. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes to provider policy

Finally, the Quality Oversight Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of restraints, as well as data from periodic and targeted provider reviews conducted by the Quality Oversight Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to the Iowa Medicaid. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

MCO community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restraints would be addressed with the provider of service and corrected as needed. In addition, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

FFS and MCO
A restrictive intervention is an action or procedure that imposes a restriction of movement that limits a member’s movement, access to other individuals, locations or activities, or restricts a member’s rights. 441-IAC 77.25(4) describes restrictive interventions as restraints, restrictions and behavioral intervention.

The HHS policy regarding restrictive interventions is as follows, and applies to all types of restraints and restrictions methods that may be used by waiver providers. The use of any restrictive intervention as part of the waiver program is treated as rights limitations of the member receiving services. As a rights limitation, the restrictive interventions must be agreed to by the interdisciplinary team and identified in the member’s plan of care (441 Iowa Administrative Code 83.67(4)).

Per 441 Iowa Administrative Code Chapter 77.25(4), providers “shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures." All members receiving home- and community-based ID Waiver services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member’s legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member’s restraint, restriction, or behavioral intervention program.
c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
e. Corporal punishment and verbal or physical abuse are prohibited.”

These safeguards are the same regardless of what type of restriction interventions are used. All restrictions must also be consistent with the Children’s Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with HHS to provide waiver services must conduct its activities in accordance with these requirements. Restriction interventions must be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

The case manager or community-based case manager has the responsibility to assess the need for the restrictive interventions, identify the specific restrictive intervention, explain why the intervention is being used, identify an intervention plan, monitor the use of the restrictive intervention, and assess and reassess need for continued use. The service plan authorizes the services to be delivered to the member and identifies how they are to be provided. Without the authorization, services cannot be provided to a member.

Providers are required to use the service plan as the basis for the development and implementation of the providers’ treatment plan. The provider is responsible for developing a plan to meet the needs of the member and to train all staff on the implementation strategies of the treatment plan, such that the restriction interventions are individualized and in accordance with the previously devised plan. Providers and the case manager or community-based case manager are responsible for documenting all behavioral interventions, including restrictive interventions, in the service plan as well as the member’s response to the intervention. Providers and case managers or community-based case managers are also required to submit critical incident reports to the Iowa Medicaid, via the IMPA, any time a restrictive intervention is utilized.

Providers are required to maintain a system for the review, approval and implementation of ethical, safe, humane and efficient behavioral intervention procedures, that inform the member and his/her legal guardian of the behavioral intervention policy and procedures at the time of entry into a facility and as changes occur. Non-aversive methods of intervention must be designed and utilized as the option of first use, prior to design or implementation of any behavioral intervention containing aversive techniques.

Behavioral intervention procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a nonaversive program. Behavioral intervention procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. Corporal punishment and verbal or physical abuse are prohibited. Restrictions may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at a minimum the following components:
- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of restrictions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Restrictions and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. A person's ability to implement a procedure must be documented in one of the following ways:
- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met:
(i) the supervisor's ability to implement the procedure has been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter a member's behaviors.

Behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter a member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager's or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements:
- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the member's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the member and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the Behavioral Intervention Program must include:
- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as, and includes, the following components:
(i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the

behavior;
(ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;
(iii) description of the conditions that precede the behavior in question;
(iv) description of what appears to reinforce and maintain the behavior; and
(v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Any restriction as part of the Behavioral Intervention Program must be considered on an individual basis after a review by the interdisciplinary team and entered into the written plan of care with specific time lines. All restrictions in the Behavioral Intervention Program are explained to the member and their legal representative and agreed upon ahead of time. Unauthorized use of restrictions would be detected via interviews with the member, their family and staff and case manager or community-based case manager; through review of critical incident reports by HHS and member's case manager or community-based case manager on a daily basis; case manager or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

A restrictive intervention is an action or procedure that imposes a restriction of movement, that limits a member's movement, access to other individuals, locations or activities, or restricts a member's rights. 441-IAC 77.25(4) describes restrictive interventions as restraints, restrictions and behavioral intervention. Per the description of restrictive interventions noted in the application (G-2-b-i)above, Iowa will need to review its inclusion of restraint as a restrictive intervention.

The first line of responsibility for overseeing the use of restrictive interventions and ensuring safeguards are in place is the member's case manager or community based case manager. The use of restrictive interventions must be assessed as needed and identified in the member's service plan. The use of restrictions would also require the development and implementation of a restrictive intervention plan and the plan would be included in the participant's service plan. The member's case manager or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restrictive interventions would be addressed with the provider of service and corrected as needed.

The State contracts with the HCBS Quality Oversight Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restrictions. The Quality Oversight Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether restrictions are appropriately incorporated into the service plan, such that restrictions are only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers, regardless if serving FFS or MCO members, are required to submit major incident reports. Categories within the incident report include inappropriate use of restrictions.

FFS
For FFS members, provider reports of restrictive interventions are entered into IMPA, which trigger milestones in IoWANS for fee-for-service members. These triggers alert case managers and prompt the Iowa Medicaid HCBS Incident Reporting Specialist to conduct a review of the restrictive intervention. If it is found that the restrictive intervention demands further investigation, the issue is passed to the HCBS Quality Oversight Unit for a targeted review. If the Quality Oversight Unit discovers that the provider is less than compliant in areas surrounding the use of restrictions, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to the Iowa Medicaid Program Integrity Unit for possible sanctions that may apply.

MCO
For MCO members, provider reports are entered into the designated MCO critical incident reporting system. In the MCO system and processes, MCO CBCMs are alerted along with the MCO Critical Incident Reporting Specialist to conduct a review of the restrictive intervention. Processes for targeted review, provider corrective actions and PI referral, if warranted, are followed as discussed in the FFS process.

CAHPS (Consumer Assessment of Healthcare Providers and Systems) Home and Community-Based Services Survey INTERVIEWS
The HCBS Quality Oversight Unit is also responsible for conducting the HCBS CAHPS survey with FFS members. The HCBS Quality Oversight Unit conduct interviews either face-to-face or via telephone, to the discretion of the member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis. The HCBS Specialists conducting CAHPS interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. MCO are responsible for research and follow up to flagged responses. General

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

Finally, the HCBS Quality Oversight Unit compiles all data related to incidents associated with the inappropriate use of restrictions, as well as data from periodic and targeted provider reviews. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to HHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

MCO community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restrictive interventions would be addressed with the provider of service and corrected as needed. In addition, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The HHS policy regarding seclusion is as follows, and applies to all types of seclusions that may be used by waiver providers, regardless of delivery system (i.e., FFS or MCO) Examples of seclusion include but are not limited to locking an member in a room, locking an member out of an area of their residence, or limiting community time. All incidents of seclusion must be documented in the member's service record and reported to the Iowa Medicaid as a critical incident. As a rights limitation, the seclusion procedures must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of seclusion must be documented in a member's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures." All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
e. Corporal punishment and verbal or physical abuse are prohibited."

The same standard is used for seclusion as a restrictive intervention. All seclusions must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with HHS to provide waiver services must conduct its activities in accordance with these requirements. Seclusion procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

Seclusion may be allowed depending on the provider's agency policy to ensure that there is an accompanying Behavioral Intervention Plan, documentation of each instance, and monitoring of its use. The use of seclusion can be considered on an individual basis after the interdisciplinary team reviews the Behavioral Intervention Plan and the plan is entered into the member's service plan of care. The provider must document the use of seclusion in the member's service file each time it was utilized by staff. The provider would be required to have a written policy approved by the HCBS Quality Oversight Unit on the supervision and monitoring of members placed in a closed room.

Seclusion procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:
- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of seclusions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Seclusions and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. A person's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (
i) the supervisor's ability to implement the procedure has been documented by a program staff person;
ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and
(iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Seclusion and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter an member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member service plan and the case manager, health home coordinator, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements.
- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the person's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the individual and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:
- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as and includes the following components:
(i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;
(ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;
(iii) description of the conditions that precede the behavior in question;
iv) description of what appears to reinforce and maintain the behavior; and
v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Seclusions must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All seclusions are explained to the member and their legal representative and agreed upon ahead of time.

Unauthorized use of seclusion would be detected via interviews with the member, their family and staff and case manager, health home coordinator, or community-based case manager; through review of critical incident reports by HHS and member's case manager, health home coordinator, or community-based case manager on a daily basis; HHS and case manager, health home coordinator, or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints). Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the HHS policy for each type of agency identified seclusion is observed and member rights are safeguarded. If it is found that a waiver provider is not observing HHS policy or ensuring a member's rights, adverse action is taken by the Iowa Medicaid, which may include sanction, termination, required corrective action, etc.

The member's case manager, health home coordinator, or community-based case manager, is responsible to monitor individual plans of care including the use of seclusion and behavioral interventions.

ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The first line of responsibility for overseeing the use of seclusion and ensuring safeguards are in place is the member's case manager, health home coordinator, or community based case manager. The use of seclusion must be assessed as needed and identified in the individual member's service plan. The use of seclusion would also require the development and implementation of a behavior plan and the plan would be included in the member's service plan. The case manager, health home coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of seclusion would be addressed with the provider of service and corrected as needed.

The State contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with seclusion. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether seclusion is appropriately incorporated into the service plan, such that seclusion is only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of seclusion. These reports are entered into IMPA, trigger milestones in IoWANS for fee-for-service members that alert case managers, health home coordinators and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of seclusion, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The HCBS Quality Oversight Unit is also responsible for conducting the HCBS CAHPS survey with waiver participants. The HCBS Quality Oversight Unit conduct interviews either face-to-face or via telephone, to the discretion of the member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis. The HCBS Specialists conducting CAHPS interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. MCO are responsible for research and follow up to flagged responses. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes to provider policy.

Finally, the Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of seclusion, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to HHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

Yes. This Appendix applies *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Per 441 Iowa Administrative Code 77.37(15), respite providers must meet the following requirements as a condition of providing respite care under the ID waiver:
(1) training on provision of medication according to agency policy and procedure; and
(2) the staff member shall not provide any direct service without the oversight of supervisory staff until training is completed.

The case manager or community-based case manager and any provider responsible for medication administration must monitor the documentation of medication administration to ensure adherence to the service plan and provider policies and procedure. The provider agency frequently and routinely monitors medication administration as outlined in their policies and procedures and quality improvement plans. Provider agencies are expected to review medication administration on a daily basis to ensure health and welfare of member as well as perform quality assurance on a timeframe identified by the agency. The case manager or community-based case manager also monitor medications at a minimum annually during the annual service plan development or more frequently as needed. MCO community-based case managers monitor the documentation of medication administration to ensure adherence to the service plan and provider policies and procedures.

Monitoring includes review of the service documentation to ensure that medications have been administered at the designated times and by designated individuals. Further monitoring occurs through the report of major incidents whenever a medication error results in physicians' treatment, mental health intervention, law enforcement intervention, death, or elopement. When a major incident has occurred, follow-up, investigation, and remediation occurs as identified in G.l.d. All medication errors resulting in a major incident report or discovered via complaint are fully investigated. If it is determined that a harmful practice has been detected, the provider agency completes a corrective action plan and may face sanctions depending on severity and negligence of the circumstance.

The Iowa Medicaid program has actively managed Medicaid pharmacy benefits through a Preferred Drug List (PDL) since 2005. A governor appointed medical assistance pharmaceutical and therapeutics (P&T) committee was established for the purpose of developing and providing ongoing review of the PDL. The prior authorization department of the Iowa Medicaid Medical Services Unit (MSU) utilizes the PDL to review medication management. First line responsibility lies with the prescriber who is contacted by fax or telephone regarding a prescription. Pharmacists review patient profiles for proper diagnosis, dosage strength and length of therapy.

The HHS Member Services Unit has established procedures to monitor Medicaid members' prescribing physicians and pharmacies. Analysis has established risk thresholds for these factors to mitigate possible abuse, harmful drug reactions, and to improve the outcomes of medication regimes for Medicaid members. When it is identified that members exceed the established risk thresholds, the member is placed in lock-in. Lock-in establishes one prescribing physician and one filling pharmacy for each member. The Member Services Unit also conducts statistical analysis of the use of certain drugs and usage patterns. Identification of trends for prescriptions and usage patterns of high risk or addictive medications is presented to HHS on a monthly or quarterly basis.

Second-line monitoring is conducted concerning the use of behavior modifying medications through a variety of mechanisms. First, member education is designed to ensure appropriate utilization (correcting overutilization and underutilization), at a minimum, and to improve adherence. Second, restriction programs, including policies, procedures, and criteria for establishing the need for the lock-in, may also be implemented. Finally, medication therapy management programs are developed to identify and target members who would most benefit, and include coordination between the participant, the pharmacist and the prescriber using various means of communication and education.

The Drug Utilization Review (DUR) Commission is a quality assurance body, which seeks to improve the quality of pharmacy services and ensure rational, cost-effective medication therapy for Medicaid members in Iowa. The commission reviews policy issues and provides suggestions on prospective DUR criteria, prior authorization guidelines, OTC coverage, and plan design issues. The DUR system provides for the evaluation of individual member profiles by a qualified professional group of physicians and pharmacists, with expertise in the clinically appropriate prescribing of covered outpatient drugs, the clinically appropriate dispensing and monitoring of outpatient drugs, drug use review, evaluations and intervention, and medical quality assurance. Members of this group also have the knowledge, ability, and expertise to target and analyze therapeutic appropriateness, inappropriate long-term use of medication, overuse/underuse/abuse/polypharmacy, lack of generic use, drug-drug

interactions, drug-disease contraindications, therapeutic duplications, therapeutic benefit issues, and cost-effective drug strengths and dosage forms. In addition, the Iowa Medicaid MSU reviews Medicaid member records to ensure that the member had a diagnosis or rational documented for each medication taken.

The Department of Inspections and Appeals (DIA) is responsible for Medicaid member's medication regimes for waiver members served in a Residential Care Facility for persons with Intellectual Disabilities (RCF/ID). All medical regimes are included in the member's record. Medications administered by the facility are recorded on a medical record by the individual who administers medication. All RCF/IDs are licensed facilities and must meet all Department of Inspections Administrative Rules to obtain an annually renewable license. Medical records are reviewed during licensure renewal. Persons administrating medication must be a licensed nurse or physician or have successfully completed a department approved medication aide course. If the provider stores, handles, prescribes, dispenses, or administers prescription or over the counter medications the provider is required to develop procedures for the storage, handling, prescribing, dispensing, or administration of medication. For controlled substances, providers must maintain DIA procedures. If the provider has a physician on staff or under contract, the physician must review and document the provider's prescribed medication regime at least annually in accordance with current medical practice. Policies and procedures must be developed in written form by the provider for the dispensing, storage, and recording of all prescription and nonprescription medications administered, monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, including antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics. Policies and procedures are reviewed by the HCBS Specialists for compliance with state and federal regulations. If deficiencies are found, the provider is required to submit a corrective action, and follow-up surveys may be conducted based on the severity of the deficiency. of the deficiency.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Second line responsibility is utilized when issues are more complex. Occurrences of high dosage use for certain medications or prescribing drugs for an age group where the drug is not FDA indicated are sent to HHS-IM for review. In some cases edits have been placed in the computer system so the prescriber could not prescribe for age groups not indicated.

Lock-In: Trending and analysis has been conducted by the MSU and "lock-in" strategies have been implemented for individuals who have, historically, multiple prescribers and pharmacies. Identification of these individuals allows the Medicaid payment of only one prescribing physician and one pharmacy. This allows for increased monitoring of appropriate medication management and mitigates the risk associated with pharmacological abuses and negative contraindications.

Drug Utilization Review (DUR) Commission: The DUR is a second line monitoring process with oversight by HHS. The DUR system includes a process of provider intervention that promotes quality assurance of care, patient safety, provider education, cost effectiveness and positive provider relations. Letters to providers generated as a result of the professional evaluation process identify concerns about medication regimens and specific patients. At least one Iowa licensed pharmacist is available to reply in writing to questions submitted by providers regarding provider correspondence, to communicate by telephone with providers as necessary and to coordinate face-to-face interventions as determined by the DUR.

The Department of Inspections and Appeals (DIA): This DIA is responsible for oversight of licensed facilities. DIA communicates all findings to HHS and any issues identified during the RCF/ID licensure process, or critical incidents as they arise. The DIA tracks information and provides training as necessary to improve quality. This information is also shared with HHS. Both the DIA and HHS follow-up with identified RCF/IDs to assure that action steps have been made to ensure potential harmful practices do not reoccur.

HCBS Quality Assurance Unit: HHS contracts with the Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with medication management. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines participant files, and conducts targeted reviews based on complaints, to ascertain whether medications are appropriately incorporated into the service plan. If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include medication errors. These reports are entered into IMPA, trigger milestones in IoWANS for fee-for-service participants that alert service workers, case managers, and health home coordinators, and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding medication management, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

With respect to MCO members, community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of medication would be addressed with the provider of service and corrected as needed. In addition, MCOs must maintain documentation of the member's medication management done by the MCOs clinical staff; monitor the prescribing patterns of network prescribers to improve the quality of care coordination services provided to members through strategies such as: (a) identifying medication utilization that deviates from current clinical practice guidelines; (b) identifying members whose utilization of controlled substances warrants intervention; (c) providing education, support and technical assistance to providers; and (d) monitor the prescribing patterns of psychotropic medication to children, including children in foster care. Finally, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa

Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.).

The Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of medication, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to HHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Supported Community Living and Respite Service providers must have policies and procedures developed for dispensing, storage, and recording all prescription and nonprescription medication administered. 441 Iowa Administrative Code Chapter 77.37(15) (b)(2)states:

“Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing. All medications shall be stored in their original containers, with the accompanying physician’s or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer’s name. In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.”

Providers are required to have staff trained on medication administration and provide safe oversight of medication administration. The State does not require specific medication administration curriculum to be used. Providers are responsible to assure that staff has the skills needed to administer medications safely. This can be done through providing staff with an outside medication management training program with a certification issued or an internal training provided by qualified medical staff. There are no uniform requirements in the Iowa Administrative Code for the provision of medication administration or for the self-administration of medications by Medicaid members. The HCBS Quality Oversight Unit verifies the training during the provider onsite review.

The Provider Self-Assessment quality improvement process requires providers to have a policy and procedure for the storage and provision of medication. This process requires a more uniform approach for the provider in the requirements for medication management. The Provider Self-Assessment review checklist used by the HCBS Specialist to review providers identifies the following minimum standards that the medication policy will identify:

- The provider’s role in the management and/or administration of medications
- If staff administers medications, the policy will identify the:
  (1) training provided to staff prior to the administration of medications;
  (2) method of documenting the administration of medications;
  (3) storage of medications;
  (4) the assessment process used to determine the Medicaid member’s role in the administration of medications.

The provider Self-Assessment process also requires providers to have discovery, remediation and improvement processes for medication administration. The information and results of these activities is available to HHS upon request. Currently the self-assessment process is not set forth in the Iowa Administrative Code.

Home Health agencies that provide waiver services must follow Medicare regulations for medication administration and dispensing. All medications must be stored in their original containers with the accompanying physician's or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to Medicaid members and the public. Nonprescription medications shall be labeled with the Medicaid member's name. In the case of medications that are administered on an ongoing long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription. All providers of respite must develop policies that assure that personnel that administer medications have the appropriate skills and that there is oversight by medical personnel.

Provider non-medical waiver staff that administers medications must have oversight of a licensed nurse. If the medication requires, the staff is required to complete a medication management course through a community college.

The requirements for non-medical waiver providers must have in order to administer medications to Medicaid members who cannot self-administer is that the provider must have a written policy in place on what the requirements are for their staff to do this and how. If the medications are psychiatric medications the person would have to have successfully completed a medication aide class. Oversight for a staff member who administers medications that require oversight such as in the case of psychiatric medications would need to follow the requirements as spelled out through the Board of Nursing such as having oversight by a registered nurse. The HCBS Specialists through Iowa Medicaid would oversee this policy upon regular reviews of the provider.

State oversight responsibility is described in Appendix H for the monitoring methods that include identification of problems in provider performance and support follow-up remediation actions and quality improvement activities.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Providers are required to complete incidents reports for all occurrences meeting the criteria for major and minor incidents and make the incident reports and related documentation available to HHS upon request. Major incidents must be reported to the BLTC via IMPA. Providers must ensure cooperation in providing pertinent information regarding incidents as requested by HHS.

As part of the major incident reporting process described in Appendix G-1, HHS will review and follow-up on all medication errors that lead to a participant hospitalization or death. This can include the wrong dosage, the wrong medication delivered, medication delivered at the wrong time, Medicaid delivery not documented, unauthorized administration of medication, or missed dosage. Providers are required to submit all medication errors, whether major or minor, to the participant’s service worker, case manager, health home coordinator, or community-based case manager when they occur. The service worker, case manager, health home coordinator, or community-based case manager monitors the errors and makes changes to the participant’s service plan as needed to assure the health and safety of the member.

The Provider Self-Assessment quality improvement process requires providers to have a policy and procedure regarding medication administration and medication management. The Provider Self-Assessment process also requires that providers have discovery, remediation, and improvement processes for medication administration and medication errors. Specifically, providers are required to have ongoing review of medication management and administration to ensure that medications are managed and administered appropriately. Providers are also required to track and trend all medication errors to assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to HHS upon request and will be reviewed as part of the ongoing Self-Assessment process conducted by the HCBS Specialists. This will include random sampling of providers, incident specific review (complaint and IR follow up) and on-site provider review held every five years. HHS is in the process of promulgating rules to establish the Provider Self-Assessment quality improvement process in the Administrative Code.

Other professionals or family members may report medication error incidents at any time as a complaint. Suspected abuse is reported to the reporting hotline operated by the Department of Health and Human Services.

(b) Specify the types of medication errors that providers are required to *record:*

Providers must track and trend all major and minor incident reports. Per Chapter 441 Iowa Administrative Code 77.25(1), "major incidents" are defined as an occurrence involving a participant during service provision that: (1) results in a physical injury to or by the participant that requires a physician's treatment or admission to a hospital; (2) results in the death of any person; (3) requires emergency mental health treatment for the participant; (4) requires the intervention of law enforcement; (5) requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; (6) constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or (7) involves a participant's location being unknown by provider staff who are assigned protective oversight. Service providers, provider staff, HHS TCM, MCO CBCM, health home coordinators, and community-based case managers are required to submit incident reports as they are witnessed or discovered. All major incidents must be reported within 48 hours of witnessing or discovering an incident has occurred, using the Iowa Medicaid's Iowa Medicaid Portal Access (IMPA) System. Suspected abuse may be reported to the statewide abuse reporting hotline operated by HHS.

Per Chapter 441 Iowa Administrative Code 77.25(1), "minor incidents" are defined as an occurrence involving a participant during service provision that is not a major incident and that: (1) results in the application of basic first aid; (2) results in bruising; (3) results in seizure activity; (4) results in injury to self, to others, or to property; or (5) constitutes a prescription medication error. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the participant's file.

Providers are required to record all medication errors, both major and minor, that occur. Providers are required to track and trend all medication errors and assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to HHS upon request and will be reviewed as part of the ongoing Self-Assessment process conducted by the HCBS Specialists.

(c) Specify the types of medication errors that providers must *report* to the state:

Only major incidents of medication errors that affect the health and safety of the member, as defined by the major incident criteria, are required to be reported to the State. All medication errors, both major and minor, are required to be reported to the member's guardian, case manager, health home coordinator, or community-based case manager.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Iowa Medicaid is responsible for the oversight of waiver providers in the administration of medications to waiver members. Oversight monitoring is completed through IMPA, the provider Self-Assessment process and monitoring of the participant by the member's case manager or community-based case manager. With respect to MCO members, community-based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of medication would be addressed with the provider of service and corrected as needed. In addition, MCOs must maintain documentation of the member's medication management done by the MCOs clinical staff; monitor the prescribing patterns of network prescribers to improve the quality-of-care coordination services provided to members through strategies such as:
(a) identifying medication utilization that deviates from current clinical practice guidelines;
(b) identifying members whose utilization of controlled substances warrants intervention;
(c) providing education, support and technical assistance to providers; and
(d) monitor the prescribing patterns of psychotropic medication to children, including children in foster care.

Finally, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.). All of these processes have been described in detail in this Appendix.

All medication errors are considered either major or minor incidents, as noted in Subsection "iii.b" above. Major incidents are reported to the department and follow the incident reporting follow up protocol of the department.

HHS contracts with the HCBS Quality Oversight Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with medication management. The Quality Oversight Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and Federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether medications are appropriately incorporated into the service plan. If the Quality Oversight Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to the Program Integrity Unit for possible sanctions (suspension, probation, termination, etc.).

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate medication administration. These reports are entered into IMPA, trigger milestones in IoWANS for fee-for-service members that alert case managers and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding medication administration, the provider is required to complete a CAP and implement the CAP to 100% compliance. Again, if it is found that the circumstances are more serious, recommendations are made to the Program Integrity Unit for possible sanctions (suspension, probation, termination, etc.).

The Quality Oversight Unit compiles all data related to incidents reported in IMPA associated with the inappropriate medication administration, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to the IM. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and

welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
HW-a3: Number and percent of member service plans that indicate the member received information on how to identify and report abuse, neglect, exploitation and unexplained deaths. Numerator: #of members service plans that indicate the members received information on how to identify and report abuse, neglect, exploitation and unexplained deaths. Denominator: Total # of member service plans reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
Other Specify:	**Annually**	**Stratified** Describe Group:

MCO and contracted entity		IA.0213 AIDS/HIV (.05%) IA.0242 ID (47%) IA.0299 BI (6%) IA.0345 PD (4%) IA.0819 CMH (4%) IA.4111 HD Waiver (9%) IA.4155 - Elderly Waiver (30%)
	Continuously and Ongoing	**Other** Specify:
	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: MCO and contracted entity	**Annually**
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
HW-a2: Number and percent of Critical Incident Reports (CIRs) including alleged abuse, neglect, exploitation, or unexplained death that were followed up on as required. Numerator: # of CIRs including alleged abuse, neglect, exploitation, or unexplained death that were followed up on as required; Denominator: # of CIRs that included alleged abuse, neglect, exploitation, or unexplained death.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
FFS and MCO CIR databases.

Responsible Party for 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:
HW-a1: Number and percent of IAC-defined major critical incidents requiring follow-up escalation that were investigated as required. Numerator: number IAC-defined major critical incidents requiring follow-up escalation that were investigated as required; Denominator: number of IAC-defined major critical incidents requiring follow-up escalation.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Data collected in the FFS and MCO CIR databases.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**

Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
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:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
HW-b1: Number and percent of unresolved critical incidents that resulted in a targeted review that were appropriately resolved. Numerator: number of unresolved critical incidents that resulted in a targeted review that were appropriately resolved; Denominator: number of unresolved critical incidents that resulted in a targeted review.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
FFS/HCBS Unit and MCO data obtained from CIR databases.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
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:
HW-b2: Number and percent of critical incidents where root cause was identified. Numerator: Number of critical incidents where root cause was identified. Denominator: # of Critical Incident Reports

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**

Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify: MCO and 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: MCO and contracted entity	**Annually**
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
HW-b3: Number and percent of emergency room visits that meet the definition of a CI where a CIR was submitted. Numerator: Number emergency room visits, that meet the definition of a CI, where a CIR was submitted; Denominator: Number of emergency room visits meeting the definition of CI.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS submitted claims and Critical events and incident reports.

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 and MCOs	**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 policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
HW-c1: Number and percent of providers that met the requirements for the use of restraint, restriction, or behavioral intervention programs with restrictive procedures. Numerator: number providers that met the requirements for use of restraint, restriction, or behavioral intervention programs with restrictive procedure; Denominator: total number of reviewed providers.

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:
Provider's policies and procedures. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.

Responsible Party for data collection/generation *(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**

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
HW-d1: Number and percent of waiver members who received care from a primary care physician in the last 12 months. Numerator: Number of waiver members who received care from a primary care physician in the last 12 months; Denominator: Number of waiver members reviewed.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
MMIS claims data

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 = 95% confidence level with +/- 5% margin of error
Other Specify: Contracted Entity	**Annually**	**Stratified** Describe Group: IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	Continuously and Ongoing	**Other** Specify:
	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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	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.

b. Methods for Remediation/Fixing Individual Problems

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

The HCBS QIO and each MCO are responsible for monitoring and analyzing data associated with the major incidents reported for members on waivers. Data is pulled from the data warehouse and from MCO reporting on a regular basis for programmatic trends, individual issues and operational concerns. Reported incidents of abuse, medication error, death, rights restrictions, and restraints are investigated further by the HCBS Incident Reporting Specialist as each report is received. The analysis of this data is presented to the state on a quarterly basis.

The HCBS Quality Oversight Unit and MCOs are also responsible for conducting the HCBS CAHPS survey with waiver participants. The HCBS Quality Oversight Unit or MCO conduct interviews either face-to-face or via telephone, to the discretion of the member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis. The HCBS Specialists conducting CAHPS interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. MCO are responsible for research and follow up to flagged responses. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes to provider policy.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify: contracted entity and MCOs	**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 Health and Welfare that are currently non-operational.

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the

waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Iowa Medicaid is the single state agency that retains administrative authority of Iowa's HCBS Waivers. Iowa remains highly committed to continually improve the quality of services for all waiver programs. Iowa Medicaid discovered over the course of submitting previous 1915(c) waiver evidence packages that previously developed performance measures were not adequately capturing the activities of the Iowa Medicaid. For this reason, state staff developed new performance measures to better capture the quality processes that are already occurring or being developed.

The QIS developed by Iowa consolidates and stratifies performance data across all seven 1915(c) waivers. The HCBS waiver population will be identified based waiver enrollment at a single point in time. A 95% confidence level with a 5% error rate for the total waiver population is calculated. In an effort to ensure each waiver is represented within the sample identified for the reporting year, the specific waiver enrollment will be divided by the total waiver population to identify the percentage the specific waiver contributes to the overall waiver population during that reporting year. The significant sample will be multiplied by the percentage identified for each waiver to identify the number of surveys/reviews that need to be completed for each waiver. This process is completed for each waiver to ensure that the 95% confidence level is met and that each waiver is appropriately sampled. A common capture date will be used to count enrollment for all waivers.

Iowa will begin consolidated performance data collection April 1, 2020. The first consolidated evidence reports will be for the Physical Disability and Health and Disability Waivers reports due to CMS in January 2021.

IA.0213 - AIDS/HIV Waiver (.05%)
IA.0242 - ID Waiver (47%)
IA.0299 - BI Waiver (6%)
IA.0345 - PD Waiver (4%)
IA.0819 - CMH Waiver (4%)
IA.4111 - HD Waiver (9%)
IA.4155 - Elderly Waiver (30%)

Based on contract oversight and performance measure implementation, Iowa Medicaid holds weekly policy staff and long term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff. Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance committee meets monthly to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. IoWANS will only be utilized for fee-for-service participants.

All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas. The QM/QI program must have objectives that are measurable, realistic and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 Subpart E and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program. The State has developed a draft-reporting manual for the MCOs to utilize for many of the managed care contract reporting requirements. The managed care contract also allows for the State to request additional regular and ad hoc reports.

Iowa has acknowledged that improvements are necessary to capture data at a more refined level, specifically individual remediation. While each contracting unit utilizes their own electronic tracking system or OnBase (workflow management), further improvements must be made to ensure that there are not preventable gaps collecting individual remediation. The State acknowledges that this is an important component of the system; however the terrain where intent meets the state budget can be difficult to manage.

Iowa Medicaid supports infrastructure development that ensures choice is provided to all Medicaid members

seeking services and that these services are allocated at the most appropriate level possible. This will increase efficiency as less time is spent on service/funding allocation and more time is spent on care coordination and improvement. A comprehensive system of information and referrals ensures that all individuals are allowed fully informed choices prior to facility placement.

The Medicaid Quality Utilization and Improvement Data System (MQUIDS) is a data entry and retrieval application designed to facilitate the Medical Services contractor's job functions including level of care determinations, medical service prior authorizations, documentation review and the retention of other pertinent member data . The content is guided by the business and policy requirements of medical review. The medical services reviews frequently involve the documentation of health information on individual members that must be protected

A comprehensive system of information and referrals shall also be developed such that all individuals are allowed fully informed choices prior to facility placement. Many program integrity and ACA initiatives will assist in system improvements. These include improvements to provider screening at enrollment, tighter sanction rules, and more emphasis on sustaining quality practices.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Quality Improvement Committee	**Annually**
Other Specify: Contracted Entities (including MCOs)	**Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Iowa Medicaid has hired a Quality Assurance Manager to oversee the data compilation and remediation activities associated with the revised performance measures. The QA Manager and State policy staff address oversight of design changes and the subsequent monitoring and analysis during the weekly policy and monthly quality assurance meetings. Prior to dramatic system design changes, the State will seek the input of stakeholders and test/pilot changes that are suggested and developed. Informational letters are sent out to all relevant parties prior to implementation with contact information of key staff involved. This workflow is documented in logs and in informational letters found within the HHS computer server for future reference. Stakeholder involvement and informational letters are requested or sent out on a weekly/monthly/ongoing basis as policy engages in the continuous quality improvement cycle.

Unit managers, policy staff and the QA committee continue to meet on a regular basis (weekly or monthly) to monitor performance and work plan activities. Iowa Medicaid Management and QA committees include representatives from the contracted units within Iowa Medicaid as well as State staff. These meetings serve to present and analyze data to determine patterns, trends, concerns, and issues in service delivery of Medicaid services, including by not limited to waiver services. Based on these analyses, recommendations for changes in policy are made to the Iowa Medicaid policy staff and bureau chiefs. This information is also used to provide training, technical assistance, corrective action, and other activities. The unit managers and committees monitor training and technical assistance activities to assure consistent implementation statewide. Meeting minutes/work plans track data analysis, recommendations, and prioritizations to map the continuous evaluation and improvement of the system. Iowa Medicaid analyzes general system performance through the management of contract performance benchmarks, IoWANS reports, and Medicaid Value Management reports and then works with contractors, providers and other agencies regarding specific issues. The QA committee directs workgroups on specific activities of quality improvement and other workgroups are activated as needed.

In addition to developing QM/QI programs that include regular, ongoing assessment of services provided to Medicaid beneficiaries, MCOs must maintain a QM/QI Committee that includes medical, behavioral health, and long-term care staff, and network providers. This committee is responsible for analyzing and evaluating the result of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action, and ensuring appropriate follow-up. This committee is also responsible for reviewing and approving the MCOs' QM/QI program description, annual evaluation, and associated work plan prior to submission to HHS.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Iowa Medicaid reviews the overall QIS no less than annually. Strategies are continually adapted to establish and sustain better performance through improvements in skills, processes, and products. Evaluating and sustaining progress toward system goals is an ongoing, creative process that has to involve all stakeholders in the system. Improvement requires structures, processes, and a culture that encourage input from members at all levels within the system, sophisticated and thoughtful use of data, open discussions among people with a variety of perspectives, reasonable risk-taking, and a commitment to continuous learning. The QIS is often revisited more often due to the dynamic nature of Medicaid policies and regulations, as well as the changing climate of the member and provider communities.

In accordance with 42 CFR 438 Subpart E, the State will maintain a written strategy for assessing and improving the quality of services offered by MCOs including, but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries. MCOs must comply with the standards established by the State and must provide all information and reporting necessary for the State to carry out its obligations for the State quality strategy. MCOs are contractually required to ensure that the results of each external independent review are available to participating health care providers, members, and potential members of the organization, except that the results may not be made available in a manner that discloses the identity of any individual patient. Further, MCOs must establish stakeholder advisory boards that advise and provide input into: (a) service delivery; (b) quality of care; (c) member rights and responsibilities; (d) resolution of grievances and appeals; (e) operational issues; (f) program monitoring and evaluation; (g) member and provider education; and (h) priority issues identified by members. In accordance with 42 CFR 438 Subpart E, the State will regularly monitor and evaluate the MCOs' compliance with the standards established in the State's quality strategy and the MCOs' QM/QI program. The State is in the process of developing specific processes and timelines to report results to agencies, waiver providers, participants, families, other interested parties and the public. This will include strategies such as leveraging the Medical Assistance Advisory Council (MAAC).

The HCBS Quality Assurance Unit (QAU) completes review of HCBS enrolled providers on a three-five year cycle. During the onsite review HCBS ensures personnel are trained in:
-Abuse reporting
-Incident reporting
-Have current mandatory reporter training
- Individual member support needs
-Rights restrictions
-Provision of member medication

In addition HCBS QAU reviews the centralized incident report file, appeals and grievances, and any allegations of abuse. During the review of service documentation any incident identified in narrative which falls under the Incident description in 77.25(3), is required to have an incident report filed. The agencies tracking and trending of incident reports is also reviewed during the onsite review. Any areas the agency may be out of compliance in results in the requirement of a corrective action plan. HCBS
gives the provider 30 days to submit a time limited corrective action plan which will remediate the deficiency. 45 days after the corrective action plan has been accepted HCBS follows up and requires the agency to submit evidence that the corrective action plan was put into place.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months ***(Select one):***

No

Yes *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

This section applies to all Intellectual Disability Waiver services, including CDAC and Personal Care Services provided through the state's self-direction program, the Consumer Choices Option (CCO). Self-directed services are not treated differently than other waiver services.

The Iowa Medicaid (IM) Program Integrity (PI) unit conducts audits on all Medicaid provider types including HCBS providers. Any suspected fraud is referred to the Department of Inspection and Appeals (DIA) Medicaid Fraud and Control Unit (MFCU). The IM PI unit vendor is contractually required to review a valid sample with a 95% confidence level with +/- 5% margin of error, based on the universe of claims to be sampled across all provider types.

The PI unit reviews include providers who are outliers on multiple parameters of cost, utilization, quality of care, and/or other metrics. Reviews include referrals and complaints received. Reviews include the review of claims data and service documentation to detect such aberrancies as up-coding, unbundling, and billing for services not rendered. The review may involve desk audits or provider on-site reviews. During a desk audit the provider is required to submit records for the PI unit to review. The PI unit must initiate appropriate action to recover improper payments on the basis of its reviews. They must work with the Core MMIS contractor to accomplish required actions on providers, including requests to recover payment through the use of credit and adjustment procedures.

Reviews conducted by the Program Integrity unit for Fee-For-Service (FFS) members are mainly done post pay; some may be done pre-pay if a specific provider has been previously reviewed and found to be out of compliance. MCOs are required to follow the same standards and processes as used for FFS.

The PI vendor must report findings from all financial integrity monthly reviews to the IM, including monthly and quarterly written reports detailing information on provider review activity, findings and recoveries. A request for provider records by the PI unit include Form 470-4479, Documentation Checklist, which lists the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)"d." to document the basis for services or activities provided. Reviews are conducted in accordance with Iowa Administrative Code 441-79.4 (https://www.legis.iowa.gov/docs/ACO/chapter/441.79.pdf).

The vast majority of HCBS claims are paid through MCOs. The IM Program Integrity unit only reviews claims submitted through the FFS system for members who are not enrolled in an MCO. There is a relatively small number of HCBS claims in the FFS universe and, as such, statistical sampling is unnecessary. Since April 2016, the IM Program Integrity Unit has reviewed and average of 1,568 ID Waiver FFS claims per month or 7.21% of the total ID Waiver claims which includes both FFS and MCO claims. It is anticipated that the state will continue with the average number of claims reviewed in the future. It is more efficient and productive for the PI unit to use more targeted strategies to identify providers for review. Strategies such as data analysis and algorithms to identify billing aberrancies, as well as referrals and complaints that come from various sources are used to identify providers. The PI vendor may conduct on-site reviews, but there is no requirement for a set percentage of reviews to be conducted on-site.

The prescribed methodology for review is determined on a case-by-case basis and is generally determined based on the nature and scope of the issue identified. In previous years, all HCBS claims were paid through the FFS system; currently the vast majority of HCBS claims are paid by MCOs. The state compares the results of the MCO program integrity efforts to the results achieved in past years. However, MCO operations tend to rely more on prior authorization of services and pre-payment claims editing to control costs, and as such this type of comparison will not be straightforward and may not provide useful information.

When the PI vendor identifies an overpayment for FFS claims, a Preliminary Report of Tentative Overpayment (PROTO) letter is sent to the provider. The PROTO letter gives the provider an opportunity to ask for a re-evaluation and they may submit additional documentation at that time. After the re-evaluation is complete, the provider is sent a Findings and Order for Repayment (FOR) letter to notify them of any resulting overpayment. Both the PROTO and FOR letters are reviewed and signed off by IM State PI staff prior to mailing. The FOR letter includes appeal rights to inform the provider that they may appeal through the State Fair Hearing process. When overpayments are recovered, claims adjustments are performed which automatically results in the federal financial participation (FFP) returned to CMS.

The IM enters into and establishes a contract with each MCO prior to assigning members to be managed by the MCO. The contract is a comprehensive document that details the requirements of the MCO in managing the Medicaid and waiver services for those members on the ID waiver. The IM sends each MCO a monthly eligibility file to identify member enrollment with the MCO for authorization of the capitated payment to the MCO. Any change in eligibility status, whether from FFS to MCO, MCO to FFS or a change from one MCO to another, is identified in the monthly eligibility file.

The Organized Health Care Delivery System (OHCDS) Medicaid audit is subject to the same standards and processes as outlined for FFS. The state's contracted MCOs are also responsible for safeguarding against, and investigating reports of, suspected fraud and abuse. MCOs are required to fully cooperate with the IM PI Unit by providing data and ongoing communication and collaboration. Per 42 CFR 438.608 and 42 CFR Part 455, MCOs must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The MCO PI Plan must be updated annually and submitted to the IM for review and approval. The MCOs are also required to make referral to the IM and the MFCU for any suspected fraudulent activity by a provider. On a monthly basis, the MCOs must submit an activity report to the IM, which outlines the MCO's PI-related activities and findings, progress in meeting goals and objectives, and recoupment totals. Each MCO is also required to meet in person with the IM PI Unit, the IM Managed Care Oversight Bureau, and the MFCU on at least a quarterly basis to coordinate on open cases and review the MCO's program integrity efforts. Iowa's MCOs continuously conduct reviews/audits on providers in their networks. The degree to which these include HCBS providers varies over time depending on tips received and leads from data analytics.

The state trends data from the MCOs monthly reports to identify trends in number of tips received, number of audits/investigations opened, the number of closed referrals to MFCU, and the amount of overpayments recovered.

The IM reviews MCO reports monthly to monitor their fraud and abuse activities. From this information, the IM analyzes and trends the data received. A monthly dashboard is created that captures metrics on number or tips, new audits and investigations, number of fraud referrals, amount of overpayments collected, and cost savings/cost avoidance numbers. These numbers are shared with IM leadership monthly and with the MCOs during their 1:1 monthly meeting with the IM Program Integrity unit. At the end of the fiscal year the current MCO stats are compared to previous years and results of this analysis is presented to IM leadership and the MCOs.

The MCOs must also coordinate all PI efforts with IM and Iowa's MFCU. MCOs must have a method in place to verify whether services reimbursed were actually provided to members as billed by providers. The methods must comply with 42 CFR Part 455 by suspending payments to a provider after the IM PI unit determines there is a credible allegation of fraud unless otherwise directed by the IM or law enforcement. MCOs shall comply with all requirements for provider disenrollment and termination as required by 42 CFR §455.

The Auditor of the State has the responsibility to conduct periodic independent audit of the waiver under the provisions of the Single Audit Act. The State Auditor's office performs an audit of the Medicaid waivers every year. The audit is performed based upon randomly selected members across all waivers and the review includes various payment types, provider agreements, eligibility, proper payment, etc.

All HCBS provider cost reports are subject to a desk review audit and, if necessary, a field audit. However, the Waiver does not require the providers to secure an independent audit of their financial statements.

Iowa requires that Managed Care Organizations have EVV information for all required PCS and Home Health Care services. Iowa reviews aggregate EVV compliance reports to understand utilization trends and EVV compliance. The following 1915(c) waiver service codes for EVV are: S5125 - Attendant Care Services Per 15 Minutes, T1019 - Personal Care Services Per 15 Minutes, S9122- HOM HLTH AIDE/CERT NURSE ASST PROV CARE HOME, S9123-NURSING CARE THE HOME; REGISTERED NURSE PER HOUR, S9124-NURSING CARE IN THE HOME; BY LPN PER HOUR, T1002-RN SERVICES UP TO 15 MINUTES, T1003-LPN/LVN SERVICES UP TO 15 MINUTES, T1004-SERVICES QUALIFIED NURSING AIDE UP TO 15 MINUTES, S1922-HOME HEALTH AIDE/CERTIFIED NURSE ASST PER VISIT.

The EVV system assists the managed care plans in validating the provision of services and monitoring the accuracy of payments for waiver services to providers.

The State Currently does not require EVV for FFS. We accept and calculate the FMAP reduction. The State will reassess FFS EVV implementation after home health EVV implementation under the managed care plans.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
FA-a1: Number and percent of FFS claims paid for services provided to waiver members for which there is a corresponding prior authorization. Numerator: Number of FFS claims paid for services provided to waiver members for which there is a corresponding prior authorization.; Denominator: Total number of reviewed paid claims

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
Program Integrity reviews claims and provider documentation for providers already under review.

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
State Medicaid Agency	***Weekly***	***100% Review***
Operating Agency	***Monthly***	***Less than 100% Review***
Sub-State Entity	***Quarterly***	***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
Other *Specify:*	***Annually***	***Stratified*** *Describe Group:*

Contracted Entity		*IA.0213 AIDS/HIV (.05%)* *IA.0242 ID (47%)* *IA.0299 BI (6%)* *IA.0345 PD (4%)* *IA.0819 CMH (4%)* *IA.4111 HD Waiver (9%)* *IA.4155 - Elderly Waiver (30%)*
	Continuously and Ongoing	***Other*** *Specify:*
	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:
FA-a2: Number and percent of clean claims that are paid by the managed care organizations within the timeframes specified in the contract. Numerator: number of clean claims that are paid by the managed care organization within the timeframes specified in the contract; Denominator: number of Managed Care provider claims.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
Claims Data Adjudicated claims summary, claims aging summary, and claims lag report

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
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 MCOs*	***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:
FA-a3: Number and percent of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for waiver services provided. Numerator: Number of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for waiver services provided; Denominator: Number of paid claims

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
State Medicaid Agency	***Weekly***	***100% Review***
Operating Agency	***Monthly***	***Less than 100% Review***
Sub-State Entity	***Quarterly***	***Representative Sample*** *Confidence Interval =*
Other	***Annually***	***Stratified***

Specify: *Contracted Entity*		*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 provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:
FA-b1: Number and percent of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology. Numerator: # of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology; Denominator: # of capitation payments to the MCO's.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
The Data Warehouse Unit query pulls paid claims data for all seven of the HCBS waivers.

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

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

The Program Integrity unit samples provider claims each quarter for quality. These claims are cross-walked with service documentation to determine the percentage of error associated with coding and documentation. This data is reported on a quarterly basis.

MCO claims data is compared to the contractual obligations for MCO timeliness of clean claim payments. Data is provided to the HCBS staff as well as to the Bureau of Managed Care.

MCO contractual definition of a clean claim: A claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity

b. Methods for Remediation/Fixing Individual Problems

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

When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments; require screening of all claims, referral to MFCU, or provider suspension.

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:*	***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 Financial Accountability that are currently non-operational.

No

Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. *Rate Determination Methods.* *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

441 IAC 79.1 sets forth the principles governing reimbursement of providers of medical and health services. Specifically, the basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member. Reimbursement types are described at 441 IAC 79.1(1).

Daily SCL, residential based SCL, full day adult day care, and full day Day Habilitation services are reimbursed using a tiered rate fee schedule published in the Iowa Administrative Code and available on hhs.iowa.gov.

Personal emergency response or portable locator system, respite, transportation, prevoc services, supported employment (SE), adult day care (15 min. and 1/2 day units), Day Habilitation (15 – min. units), financial management services, independent support broker and home and vehicle modification are reimbursed by fee schedules. The fee schedule is the actual charge made by the provider not to exceed the upper payment limit (UPL). The UPL is established to address the reasonableness of the charge. If the provider rate is under the upper max, it is reasonable.

The following services may be rendered via telehealth under this waiver: SCL and SE. When services are delivered via telehealth, reimbursement is the same as if the services were rendered in person.

Fee schedules are determined by HHS Iowa Medicaid with advice and consultation from the appropriate professional group at the time the fee schedule is first developed. Individual service rate adjustments are made periodically to correct any rate inequity. With the ID waiver, this is a legislative appropriation process through provider association and individual providers lobbying efforts. The legislature can direct IM to increase or decrease rates through a legislative mandate. There is no set cycle for the Legislature to change rates. The IM will change the IAC Rules accordingly. All provider rates are part of IAC and are subject to public comment any time there is a rate rule change. Information is on the website and is distributed to stakeholders when there is a change. Rate determination methods are set forth in IAC and subject to the State's Administrative Procedures Act, which requires a minimum twenty-day public comment period. How the State solicits public comments on rate determination methods can be found in Main, section 6-I. When the legislature appropriates increases for provider agency reimbursement rates the CCO rates for waiver services are increased by the same percentage.

HCBS reimbursement methodologies are reviewed every five years, at a minimum. When the department reviews reimbursement levels for adequacy; historical experience, current reimbursement levels, experiences in other states, and network adequacy are considered. The results of the benchmarking indicate whether the rates are adequate to maintain an ample provider network or if legislative appropriation is necessary to increase or align rates.

Oversight of the rate determination process is conducted by IM. IM Provider Cost Audit and Rate Setting unit, compiles the data needed to complete the rate calculations, prepares the report, performs the review of calculations and reports, and submits the report to IM for review and approval. Iowa Medicaid budget analyst and actuary review the rate calculations to determine accuracy.
If product cost is involved, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:
(1) The actual charge made by the provider of service.
(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Variations in this methodology are set forth in subrules IAC 79.1(3) to 79.1(9) and 79.1(15). Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website at: https://hhs.iowa.gov/ime/providers/csrp/fee-schedule.

SCL provided in 15- minute units is a retrospectively limited prospective rate. With this rate, providers are reimbursed on the basis of a rate for a unit of service calculated prospectively based on projected or historical costs of operation.
•The prospective rates for new providers who have not submitted 6 months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of 6 months of actual costs.

•The prospective rates paid established providers who have submitted an annual report with a minimum of a 6-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.
•The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 5.5 percent.

The base rates for intermittent SCL is recalculated no less than every three years. Rates where rebased using the 2022 financial and statistical report. The base rates will be recalculated based on the reasonable and proper costs of operation for the provider's fiscal year ending on or after January 1, 2024

Interim Medical Monitoring and Treatment rates are established two ways and is based on the enrollment type of the IMMT provider. IMMT services provided by a supported community living provider is a retrospectively limited prospective rate as noted for SCL provided in 15 – minute units above. IMMT provided by a home health agency is a cost-based rate for home health aide services provided by a home health agency. The difference in how rates are developed for IMMT is due to the use of existing rate setting methodologies for services similar to IMMT. An SCL provider will use the same rate setting methodology for IMMT as it does for SCL 15- minutes units since the service costs for both SCL and IMMT are the same or very similar. IMMT provided by a home health agency will use the same rate setting methodology used for a home health aide as they would be the same or similar cost for providing IMMT.

CDAC (Skilled and Unskilled) are reimbursed on the basis of the agreement of the member and the provider with an upper payment limit established by the State.

For services that the participant self-directs (CCO), the member negotiates a rate with the entity providing services, goods, and supports.

Individual and Agency Consumer Directed Attendant Care (CDAC) (Skilled and Unskilled) providers are reimbursed on the basis of the agreement of the member and the provider. The rate determination for self-directed services, under CCO, are reimbursed according to the methodology in section E-1-a. CDAC services, individual and agency, are reimbursed at a rate agreed upon between the CDAC provider and the member, not to exceed the upper payment limit in IAC.

For the FMS and ISB services, the IM sets the upper rate limit for those services as established in IAC 441-79.1(2).

To determine a member's CCO budget amount, the department determines the average unit cost for each service available for use in CCO based on actual unit costs of the service as billed by the enrolled Medicaid providers from the previous fiscal year plus a cost-of-living adjustment. The available services are: Day Hab, CDAC, SCL, HMV, Transportation, Respite, SE, and Prevoc. In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department applies a utilization adjustment factor to the amount of service authorized in the member's service plan. The department computes the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The individual budget rate setting methodology is stated in the 441 Iowa Administrative Code Chapter 78.41(15). In addition, this information is shared during all outreach and training held throughout the State for members, families, and other advocates. The MCOs are also responsible for making the budget methodology available to members through their case managers and member communication materials.

Respite provided by home health agencies use the maximum Medicare rate converted to a fifteen-minute unit.

Home health aide and nursing Services are based on a fee schedule as determined by Medicare.

For transportation, the rate is fee schedule. Providers are paid at the provider's rate, not to exceed the upper rate limit at 441 IAC 79.1(2).

Prevocational service rates are fee schedules.

Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices. For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality. Payment for used equipment shall not exceed 80 percent of the purchase allowance. No allowance shall be made for delivery, freight, postage, or other the CDAC and CCO services were set in accordance with 441 IAC 79.1(1)c.

During service plan development, the CM shares with the member the rates of the providers, and the member can chose a provider based on their rates. When a service is authorized in a member's service plan, the providers receive a Notice of Decision, which indicates the participant's name, provider's name, service to be provided, the dates of service to be provided, units of service authorized, and reimbursement rate for the service.

MCO capitation rate development methodologies are described in the §1915(b) waiver and associated materials. MCO rates are blended between fee-for-service and managed care capitated payments based on the anticipated percentage of unduplicated participants per delivery system.

Effective November 1, 2023, new services medical day care for children and enabling technology for remote support are reimbursed by fee schedule.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

For fee-for-service participants, providers shall submit claims on a monthly basis for waiver services provided to each member served by the provider agency. Providers may submit manual or electronic claim forms. Electronic claims must utilize a HIPAA compliant software, as identified in the provider billing manual. Claims submitted manually shall be directed to the Iowa Medicaid (IM)/Provider Services Unit.

Fee for Service provider billing manuals are located at https://hhs.iowa.gov/ime/providers/rulesandpolicies. Waiver service fee schedule upper payment rates are located in the Iowa Administrative Code at https://hhs.iowa.gov/ime/providers/rulesandpolicies, Chapter 79.

Providers shall submit a claim form that accurately reflects the following:
(1) the provider's approved NPI provider number;
(2) the appropriate waiver procedure code(s) that correspond to the waiver services authorized in the IoWANS service plan; and
(3) the appropriate waiver service unit(s) and fee that corresponds to the IoWANS service plan.

The member's name and identification number are both also required on the claim form.

For the Consumer Choices Option (CCO), the flow of billing by the Financial Management Service (FMS) is the same as other HCBS Waiver enrolled providers, i.e., once the CCO services have been provided, the FMS will bill for the CCO services provided in the previous month based on the services provided to the member by the CCO employee(s). The FMS pays the CCO employees and for the individual directed goods and services during the month then bills for services through the MMIS system.

The IM issues provider payments weekly on each Monday of the month. The MMIS system edits ensure that payment will not be made for services that are not included in an approved IoWANS service plan. Any change to IoWANS data generates a new authorization milestones for the case manager. The IoWANS process culminates in a final IoWANS milestone that verifies an approved service plan has been entered into IoWANS. IoWANS data is updated daily into MMIS.

For MCO members, providers bill the managed care entity with whom a member is enrolled in accordance with the terms of the provider's contract with the MCO. Providers may not bill Medicaid directly for services provided to MCO members.

MCOs are required to submit encounter data in accordance with 42 C.F.R. § 438.604(a)(1); 42 C.F.R. § 438.606; 42 C.F.R. § 438.818. {From CMSC I.2.01}.

Encounter data shall be submitted by the twentieth (20th) of the month subsequent to the month for which data is reflected. All corrections to the monthly encounter data submission shall be finalized within forty-five (45) Days from the date the initial error report for the month was sent to the Contractor or fifty-nine (59) Days from the date the initial encounter data was due. The error rate for the encounter data shall not exceed one percent (1%). For every service provided, providers must submit corresponding Claim or encounter data with Claim detail identical to that required for fee-for-service Claims submissions.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. ***Billing Validation Process.*** *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The MMIS system edits to make sure that claim payments are made only when a member is eligible for waiver payments and when the services are included in the service plan. An member is eligible for a Medicaid Waiver payment on the date of service as verified in IoWANS. The billing validation method includes the date the service was provided, time of service provision, and name of actual member providing the service. Several entities monitor the validity of claim payments:
(1) case manager, or health home coordinator ensures that the services were provided by reviewing paid claims information made available to them for each of their members through IoWANS;
(2) the Iowa Department of Health and Human Services Bureau of Purchased Services performs financial audits of providers to ensure that the services were provided;
(3) the IM Program Integrity Unit performs a variety of reviews by either random sample or outlier algorithms.

The MMIS system includes system edits to ensure that prior to issuing a capitation payment to an MCO the member is eligible for the waiver program and is enrolled with the MCO. MCOs must implement system edits to ensure that claim payments are made only when the member is eligible for waiver payments on the date of service. The MCOs are required to develop and maintain an electronic community-based case management system that captures and tracks service delivery against authorized services and providers. The State monitors MCO compliance and system capability through pre-implementation readiness reviews and ongoing monitoring such as a review of sampled payments to ensure that services were provided and were included in the member's approved plan of care. The MCOs are also responsible for program integrity functions with HHS review and oversight.

When inappropriate billings are discovered (i.e.: overpayments determined) the provider is notified in writing of the overpayment determination. The provider either submits a refund check to the IM or the overpayment is set as a credit balance within the MMIS. Future claim payments are then used to reduce and eliminate the credit balance.

Meanwhile, the overpayments are recorded and reported to the state data warehouse using an end-of-month A/R reporting process. Any overpayments determined during a particular month are reported for that month. Any recoveries of these overpayments are similarly recorded and reported to the state data warehouse using the same end-of-month A/R process and for the month in which the recoveries were made. The dates on which the respective overpayments occurred and the recoveries made are part of this month-end A/R reporting. Bureau of Fiscal Management staff then extracts this reporting from the data warehouse to construct the CMS-64 report, the official accounting report submitted by the Department to CMS (the state's claiming mechanism for FFP). The CMS-64 report shows CMS what Iowa's net expenditures are for the quarter and is used to determine a final claim of federal funds. The federal dollar share of any overpayments not recovered within 12 months of the payment itself must be returned to CMS and this is accomplished through the CMS-64 report as well.

Prevention of member coercion:
The case managers and MCO community based case managers are responsible for conducting the interdisciplinary team for each member and ensuring the unencumbered right of the member to choose the provider for each service that will meet the member's needs.

The HCBS Unit completes the Iowa Personal Experience Survey to a random sample of members (95% confidence level). A specific survey question relates to the members' ability to choose their providers. Any indication of coercion will result in follow up action by the HCBS staff.

The IM HCBS Unit observes a random sample of interdisciplinary team (IDT) meetings conducted by MCO community based case managers. This allows the HCBS Unit to note any member coercion in choice of providers. HCBS staff then requests the final service plan to ensure that the final plan does include the services, units and providers chosen by the member. Any changes and omissions require follow up by the HCBS staff for resolution by the MCO.

As described in I-1, EVV is currently only applicable to Personal Care Services delivered under managed care. The EVV system assists the managed care plans in validating the provision of services and monitoring the accuracy of payments for waiver services to providers. The EVV vendor reviews all service documentation entries prior to submitting the claims for payment to the MCOs. The following 1915(c) waiver service codes for EVV are: S5125 - Attendant Care Services Per 15 Minutes, T1019 - Personal Care Services Per 15 Minutes, S9122- HOM HLTH AIDE/CERT NURSE ASST PROV CARE HOME, S9123-NURSING CARE THE HOME; REGISTERED NURSE PER HOUR, S9124-NURSING CARE IN THE HOME; BY LPN PER HOUR, T1002-RN SERVICES UP TO 15 MINUTES, T1003-LPN/LVN SERVICES UP TO 15 MINUTES, T1004-SERVICES QUALIFIED NURSING AIDE UP TO 15 MINUTES, S1922-HOME HEALTH

AIDE/CERTIFIED NURSE ASST PER VISIT

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services for fee-for-service enrollees are made by HHS through the MMIS. For fee-for-service members, providers shall submit claims on a monthly basis for waiver services provided to each member served by the provider agency. Providers may submit manual or electronic claim forms. Electronic claims must utilize a HIPAA compliant software, PC-ACE Pro 32, and shall be processed by the IM Provider Services Unit. Manual claims shall be directed to the Iowa Medicaid (IM)/Provider Services Unit. Providers shall submit a claim form that accurately reflects the following: (1) the provider's approved NPI provider number; (2) the appropriate waiver procedure code(s) that correspond to the waiver services authorized in the IoWANS service plan; and (3) the appropriate waiver service unit(s) and fee that corresponds to the IoWANS service plan.

The IM issues provider payments weekly on each Monday of the month. The MMIS system edits insure that payment will not be made for services that are not included in an approved IoWANS service plan. Any change to IoWANS data generates a new authorization milestone for the case manager or health home care coordinator. The IoWANS process culminates in a final IoWANS milestone that verifies an approved service plan has been entered into IoWANS. IoWANS data is updated daily into MMIS.
For payments made by the IM: Providers are informed about the process for billing Medicaid directly through annual provider training, IM informational bulletins, and the IM provider manual. When a provider has been enrolled as a Medicaid provider, IM Provider Services mails the provider an enrollment packet that includes how the provider can bill Medicaid directly. The Provider billing manual is also available on the Iowa HHS website at: https://hhs.iowa.gov/policy-manuals

Capitation payments to MCOs are made by the MMIS. The MMIS has recipient eligibility and MCO assignment information. When a recipient is enrolled in an MCO, this is reflected on his/her eligibility file and monthly payment flows from the MMIS to the MCO via an 837 transaction. A monthly payment to the MCO on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

The claim details submitted for payment is reviewed and reconciled by the IM and supporting claim detail is maintained. Payment for these services is recorded in the state's accounting system. The accounting records and claim detail provide the audit trail for these payments.

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For payments made by Iowa Medicaid:
Providers are informed about the process for billing Medicaid directly through annual provider training, Iowa Medicaid informational bulletins, and the Iowa Medicaid provider manual.

When a provider has been enrolled as a Medicaid provider, Iowa Medicaid Provider Services mails the provider an enrollment packet that includes how the provider can bill Medicaid directly. The Provider billing manual is also available on the Iowa HHS website at: https://hhs.iowa.gov/policy-manuals.

Iowa Medicaid identifies the Financial Management Service (FMS) provider as the limited fiscal agent. The FMS directly pays the CCO self-directed services and individual directed goods Member employees through the Consumer Choices Option (CCO) program are issued instructions on billing through the FMS as authorized on the member's monthly CCO budget. The FMS bills through the MMIS system the self-directed services and individual directed goods that have been paid by the FMS during the previous month. The FMS bills through the MMIS system in the month following the provision of self-directed services.

Payment for services by the FMS include: CDAC (unskilled), day hab, HVM, prevocational services, individual respite, SCL, SE, and transportation services.

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

For MCO enrollees, for the self-direction option of the waivers, payments will be made to a FMS. Providers are informed about the process for billing by the MCO. The FMS must meet the provider qualifications established by

the state, pass a readiness review approved by the state, and be enrolled as a Medicaid provider with the state. The state will also oversee the operations of the FMS by providing periodical audits. When a member is being managed by a MCO, all waiver and Medicaid services that a member can receive are paid through the MCO and that there are no waiver services reimbursed outside of the capitated payments.

Iowa Medicaid exercises oversight of the fiscal agent through both the IoWANS system and through the Iowa Medicaid Core Unit. The Iowa Medicaid Core Unit performs a myriad of functions for Iowa Medicaid including, but not limited to, processing and paying claims, handling mail, and reporting. This unit also maintains and updates the automated eligibility reporting system known as ELVS. Iowa Medicaid has regularly scheduled meetings with Core that has thresholds of measurements they are required to meet to assure quality.

Additional oversight is provided to the program by the Iowa Medicaid Program Integrity (PI) payment review detailed in appendix I-1 of this amendment. The Iowa Administrative Code (IAC) for the FMS requires the FMS to conduct an annual independent audit. The FMS also has an on-site review conducted by the HCBS Quality Oversight Unit (QOU). As part of the Quality Assurance contract with the Iowa Medicaid, the HCBS QOU reviews the FMS provider for compliance with State and federal requirements. The FMS is an enrolled Medicaid waiver provider and as such, the Home and Community Based QOU conducts an on-site FMS quality assurance review every three years.

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. ***Supplemental or Enhanced Payments.*** *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. ***Payments to state or Local Government Providers.*** *Specify whether state or local government providers receive payment*

for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

Yes. State or local government providers receive payment for waiver services. *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The two State Resource Centers (Woodward and Glenwood) are the only two state agencies that provide community-based services on the Intellectual Disabilities waiver. The Resource Centers provide Supported Community Living, Supported Employment and respite services. All HCBS services provided by the State Resource Centers are provided in settings that are in compliance with the HCBS settings rules.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

For fee-for-service enrollees, providers receive and retain 100% of the amount claimed to CMS for waiver services. The payment to capitated MCOs is reduced by a performance withhold amount as outlined in the contracts between HHS and the MCOs. The MCOs are eligible to receive some or all of the withheld funds based on the MCO's performance in the areas outlined in the contract between HHS and the MCOs.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

Enrolled Medicaid providers can choose to subcontract to non-enrolled providers for the provision of Home and Vehicle Modifications. The authorization for the service and the Medicaid payment for the authorized service is made to the enrolled Medicaid provider that would then forward payment to the subcontractor in accordance with their contract.

Any subcontractor who is qualified to enroll with Iowa Medicaid is encouraged to do so. No provider is denied Medicaid enrollment for those services that they are qualified to provide. Waiver providers are not required to contract with an OHCDS in order to furnish services to members.

When the case manager or community-based case manager has assessed the need for any waiver service, the member is offered the full choice of available providers. The member has the right to choose from the available providers; the list of providers is available through the case manager or community-based case manager, and is also available through the IM and MCO websites. In accordance with the Iowa Administrative Code, all subcontractors must meet the same criteria guidelines as enrolled providers and the contracting enrolled provider must confirm that all criteria is met.

The Financial Management Services entities are designated as an OHCDS as long as they meet provider qualifications as specified in C-3. The FMS is the only ID waiver provider designated as an OHCDS.Iowa Medicaid (the state Medicaid agency) executes a provider agreement with the OHCDS providers and MCOs contract with an IM enrolled Financial Management Services solution. The Financial Management Services provided by the OHCDS is voluntary and an alternative billing and access is provided to both waiver members and providers. Members have free choice of providers both within the OHCDS and external to these providers. Providers may use the alternative certification and billing process developed by the Iowa Medicaid. Members are given this information during their service plan development. Providers are given this information by the OHCDS. The Designated OHCDS reviews and certifies that established provider qualifications have been met for each individual or vendor receiving Medicaid reimbursement. Annually each provider will be recertified as a qualified provider.

Employer/employee agreements and timesheets document the services provided if waiver members elect to hire and manage their own workers. The purchase of goods and services is documented through receipts and/or invoices. For each purchase for fee-for-service members, Medicaid funding from the MMIS to the provider of the service is accurately and appropriately tracked through the use of Iowa's IoWANS system. Financial oversight and monitoring of the OHCDS is administered by the Iowa Medicaid through an initial readiness review to determine capacity to perform the waiver services and throughout the year using a reporting system, random case file studies and the regular Medicaid audit process. MCOs are contractually required to develop a system to track all OHCDS Financial Management Services, which is subject to HHS review and approval. Further, the MCOs maintain financial oversight and monitoring with ongoing review and authority retained by HHS.

A provider must enroll with Medicaid prior to being eligible to enroll with a managed care organization. They are not required to contract with a MCO as this is a provider/MCO contractual arrangement. However, Medicaid will notify the MCO of all providers eligible to provide services.

Each MCO has different systems that maintains authorized service plans. Many of the services are prior authorized and claims are adjudicated against the authorizations.

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d)

how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. *State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.* *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. *Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.* *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

Not Applicable*. There are no local government level sources of funds utilized as the non-federal share.*

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. *Information Concerning Certain Sources of Funds.* *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

As specified in Iowa Administrative Code, Iowa does not reimburse for room and board costs, except as noted for providers of out-of-home respite services. The provider manuals contain instructions for providers to follow when providing financial information to determine rates. The manuals state that room and board cannot be included in the cost of providing services. Most respite payments are based upon fee schedules detailed in the Iowa Administrative Code. The fee schedule has no allowance for room and board charges. Respite provided by a home health agency is limited to the established Medicare rate.

The exclusion of room and board from reimbursement is ensured by the Provider Cost Audit Unit. When providers submit cost report documentation and rate setting changes, the Provider Cost Audit Unit accounts for all line items and requests justification for all allocated costs (administrative and other). If it is determined that a provider has attempted to include room and board expenses in cost audits or rate setting documentation, the provider is instructed to make the adjustment and further investigation is conducted to determine if previous reimbursement needs to be recouped by the Iowa Medicaid.

All providers of waiver services are subject to a billing audit completed by the Department of Health and Human Services Bureau of Purchased services.

Any payment from an MCO to residential settings is made explicitly for the provision of services as defined by this waiver and excludes room and board. As part of the ongoing monitoring process of MCOs, the State will ensure that payments to residential settings are based solely on service costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	47547.71	4504.00	52051.71	135319.42	6543.54	141862.96	89811.25
2	48983.87	4639.12	53622.99	139379.00	6739.85	146118.85	92495.86
3	50463.13	4778.29	55241.42	143560.37	6942.04	150502.41	95260.99
4	51986.61	4921.64	56908.25	147867.18	7150.30	155017.48	98109.23
5	53562.22	5069.29	58631.51	152303.20	7364.81	159668.01	101036.50

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	14780	14780

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 2	14780	14780
Year 3	14780	14780
Year 4	14780	14780
Year 5	14780	14780

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay (ALOS) is expected to remain the same throughout the five years of the waiver. The ALOS days were based on historical data supporting the Intellectual Disability (ID) waiver. The CMS 372 report data used to develop and report ALOS is from the two-year period from July 1, 2021 – June 30, 2023. This data is or will be the basis for the ID waiver 372 reports submitted in December 2023 and December 2024.

Unduplicated participants in the current ID waiver renewal are based on maximum waiver caps approved by CMS. The total unduplicated number of participants remains even over the five years of the current renewal and is set at 14,780 (WY5 of the prior renewal) to maintain the same count as was in effect on April 1, 2021, to satisfy the requirements of the current ARPA MOE that is in effect. Once the ARPA MOE expires the state will review the actual unduplicated count. Unduplicated counts in the active ID waiver were established with minimal managed care experience.

The number of unduplicated participants reflects the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.

Limitation on the Number of Participants Served at any Point in Time remains constant each year based on historical growth, average monthly costs per recipient on the waiver and maximum waiver caps approved by CMS.

Both the unduplicated number of participants and the limitation on the number of participants are based on CMS guidance.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D is impacted by the transition from a fee-for-service program to a managed care capitation rate program. In the prior waiver period, Factor D was adjusted due to the transition to managed care. Now with increased managed care experience, Factor D projections are derived from the estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program.

Sources of data used to develop Factor D are as follows:

•372 report data for the two-year period from July 1, 2021 – June 30, 2023 (submitted December 2023 and December 2024).
•The factor estimates from the actuarial report 'Factor Estimate Summary for HCBS Populations' on a SFY 2024 Basis. This actuarial report is provided by the State's
actuary and is based on Iowa's SFY24 (July 1, 2023 - June 30, 2024) capitation rates and not actual overall waiver experience.
•CPI for All Urban Consumers (CPI-U) Index for the 5-year period average of 10/01/17 - 09/30/22.

The unduplicated count was set at 14,780 (WY5 of the prior renewal) to maintain the same count as was in effect on April 1, 2021, to satisfy the requirements of the current ARPA MOE that is in effect. The number of users in the waiver application is based on actual experience from the states past two year's 372 data available. Both factors are causing the Factor D estimate to be lower for this submission.

Once the ARPA MOE expires the state will review the actual unduplicated count, number of users, and expenditures to re-evaluate the projected Factor D values in the remaining waiver years. If adjustments are needed the state will submit amendments to the waiver as necessary.

The number of users, average units, and average cost per unit for WY1 were based on the two-year average from the two most recent waiver years of the current ID waiver to be certain a reasonable level of managed care experience (managed care was implemented effective April 1, 2016) was incorporated into the trends. The referenced two-year period is from July 1, 2021 – June 30, 2023. This data is or will be the basis for the ID waiver 372 reports submitted in December 2023 and December 2024.

The calculations of Factor D (number of users and average cost per unit) for waiver year's 2 through 5 were both trended at 1.5% for a total annual trend of 3% in increased expenditures. This was based on the CPI for All Urban Consumers (CPI-U) Index for the five-year period average of 10/01/17 - 09/30/22. Average units per user over the five- year renewal have been adjusted from the last renewal based on the trending of the number of users and units. Outside of the 3.0% total trend (1.5% each for number of users and average cost per unit), Factor D for waiver year's 2 through 5 is significantly lower in the proposed waiver renewal due to the unduplicated count of 14,780 across all five years of the renewal that are aligned with the CMS maximum previously discussed above.

The new participants are not expected to change the characteristics (risk profile) of the population. The underlying capitation rates reflect the risk profile of those qualifying for the HCBS waiver, which are reflected in Factor D and Factor D'. The increase in the waiver program reflects the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is impacted by the transition from a fee-for-service program to a managed care capitation rate program. In the prior waiver period, Factor D' was adjusted due to the transition to managed care. The source for the WY1 Factor D' estimate is the 'Factor Estimate Summary for HCBS Populations' actuarial report based on Iowa's SFY24 (July 1, 2023 - June 30, 2024) capitation rates and not on actual overall waiver experience. This actuarial report calculated Factor D', G, and G' values based on Iowa's SFY 2024 capitation rates for HCBS populations in total.

The 'Factor Estimate Summary for HCBS Populations' actuarial report was determined to be the most accurate basis for calculating the Factor D' and G' estimates. As a result, Factor G' on the actuarial report and in WY1 is greater than Factor D'.

The IA Health Link is a mandatory managed care plan for the delivery of HCBS waiver services, ICF/ID and all other Medicaid state plan services. The actuarial rate data for the Health Link program represents the only comprehensive data source for HCBS, institutional and Medicaid state plan expenditures for the IFC/ID and ID Waiver HCBS populations. The estimates provided were based on evaluating Health Link rate cohort information for ID HCBS and IFC/ID members. Within the calculations we note that Factor D' is based on medical costs. Managed care costs typically included in the capitated rates such as state directed payment (separate payment terms, MCO administrative cost, MCO risk/profit and contingency loading are excluded from the per capita amounts.

A trend was not applied to the WY1 estimate from the SFY24 source data. The actuarial report was determined to be the most accurate basis for calculating the estimate. The source of the WY1 Factor D' estimate is the 'Factor Estimate Summary for HCBS Populations' actuarial report based on Iowa's SFY24 (July 1, 2023 - June 30, 2024) capitation rates and not on actual overall waiver experience. The capitation rates were used by the actuary and not the State to develop the estimate. Factor D' on the actuarial summary report is $4,504, the projection for WY1.

A 3.0% trend on the WY1 Factor D' estimate was applied for each of the remaining waiver years (2-5). The 3.0% annual increase over the five-year renewal period is trended based on a five-year average of the CPI for All Urban Consumers (CPI-U) Index for the period of 10/01/17 - 09/30/22.

New participants are not expected to change the characteristics (risk profile) of the population. The underlying capitation rates reflect the risk profile of those qualifying for the HCBS waiver, which are reflected in Factor D and Factor D'. The increase in the waiver program reflects the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

In the prior waiver renewal period, Factor G was adjusted due to the transition to managed care. In the current waiver renewal period, Factor G is based on the estimated annual average per capita Medicaid cost for hospital care that would be incurred for individuals served in the waiver, were the waiver not granted. Changes in population do not impact the calculation of Factor G and/or Factor G' with increases in the waiver program reflecting the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.

The source used to support the current Factor G estimate is the actual report 'Factor Estimate Summary for HCBS Populations' calculated on a SFY 2024 Basis and based on Iowa's SFY24 (July 1, 2023 - June 30, 2024) capitation rates. The actuarial report calculated Factor D', G, and G' values on a SFY 2024 Basis and was based on Iowa's SFY 2024 capitation rates for HCBS populations in total and on institutional Medicaid costs for persons receiving institutional care.

Waiver year (WY) 1 Factor G estimates are based on the institutional Medicaid costs for persons receiving institutional care and not on actual overall waiver experience provided. A trend was not applied to the WY1 estimate from the SFY24 source data. The actuarial report was determined to be the most accurate basis for calculating the estimate. The Factor G estimate on the actuarial summary report for WY1 is $135,319.

The ID waiver Factor G and G' were developed based on the Intermediate Care Facilities for individuals with Intellectual disability (ICF/ID) rating components from the states Mandatory Medicaid Managed care program, IA Health Link. The IA Health Link program is an integrated managed care program for the management and delivery of all Medicaid covered services through managed care plans. The IA Health Link capitation rate development includes separate rate cells for individuals who are receiving care from ICF/ID facilities and those in HCBS waivers. These individuals, their member months, and unique counts were selected to establish the G and G' per capita amounts. This data selected ICF/ID services for establishing Factor G, while all other Medicaid state plan services, that were not ICF/ID were selected to establish Factor G.

Factor G waiver years 2-5 are trended off WY1 at 3.0% for each waiver year. The 3.0% annual increase of the WY 2-5 renewal period is trended based on a five-year average of the CPI for All Urban Consumers (CPI-U) Index for the five-year period of 10/01/17 - 09/30/22.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

In the prior waiver renewal period, Factor G' was adjusted due to the transition to managed care. In the current waiver renewal period, Factor G' is based on the estimated annual average per capita Medicaid cost for hospital care that would be incurred for individuals served in the waiver, were the waiver not granted. Changes in population do not impact the calculation of Factor G and/or Factor G' with increases in the waiver program reflecting the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.

The source used to support the current Factor G' estimate is the actual report 'Factor Estimate Summary for HCBS Populations' calculated on a SFY 2024 Basis and based on Iowa's SFY24 (July 1, 2023 - June 30, 2024) capitation rates. The actuarial report calculated Factor D', G, and G' values on a SFY 2024 Basis and was based on Iowa's SFY 2024 capitation rates for HCBS populations in total and on institutional Medicaid costs for persons receiving institutional care.

Waiver year (WY) 1 Factor G' estimates are based on the institutional Medicaid costs for persons receiving institutional care and not on actual overall waiver experience provided. A trend was not applied to the WY1 estimate from the SFY24 source data. The actuarial report was determined to be the most accurate basis for calculating the estimate. The Factor G' estimate on the actuarial summary report and for WY1 is $6,544.

The ID waiver Factor G and G' were developed based on the Intermediate Care Facilities for individuals with Intellectual disability (ICF/ID) rating components from the states Mandatory Medicaid Managed care program, IA Health Link. The IA Health Link program is an integrated managed care program for the management and delivery of all Medicaid covered services through managed care plans. The IA Health Link capitation rate development includes separate rate cells for individuals who are receiving care from ICF/ID facilities and those in HCBS waivers. These individuals, their member months, and unique counts were selected to establish the G and G' per capita amounts. This data selected ICF/ID services for establishing Factor G, while all other Medicaid state plan services, that were not ICF/ID were selected to establish Factor G'.

Factor G' waiver years 2-5 are trended off WY1 at 3.0% for each waiver year. The 3.0% annual increase of the WY 2-5 renewal period is trended based on a five-year average of the CPI for All Urban Consumers (CPI-U) Index for the five-year period of 10/01/17 - 09/30/22.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Care	
Day Habilitation	
Prevocational Services	
Residential Based Supported Community Living	
Respite	
Supported Employment	
Home Health Aide Services	
Nursing	
Financial Management Services	
Independent Support Broker	
Individual Directed Goods and Services	
Self Directed Community Support and Employment	
Self Directed Personal Care	
Consumer Directed Attendant Care (CDAC) - skilled	
Consumer Directed Attendant Care (CDAC) - unskilled	

Waiver Services	
Enabling Technology for Remote Support	
Home and Vehicle Modification	
Interim Medical Monitoring and Treatment	
Medical Day Care for Children	
Personal Emergency Response or Portable Locator System	
Supported Community Living	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							4676229.22
Adult Day Care - 15 Minutes		15 Minutes	6	359.43	16.67	35950.19	
Adult Day Care - Full Day		Full Day	387	37.77	264.15	3861077.91	
Adult Day Care - Half Day		Half Day	250	19.71	137.96	679797.90	
Adult Day Care - 15 Minutes - FFS		15 Minutes	1	359.43	16.67	5991.70	
Adult Day Care- Full Day - FFS		Full Day	8	37.77	264.15	79815.56	
Adult Day Care - Half Day - FFS		Half Day	5	19.71	137.96	13595.96	
Day Habilitation Total:							45589725.48
Day Habilitation, ID Waiver, Per Day		Day	2509	46.91	295.76	34810120.91	
Day						9924743.35	

GRAND TOTAL:	**702755226.92**
Total: Services included in capitation:	557560458.95
Total: Services not included in capitation:	145194767.97
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**47547.71**
Services included in capitation:	37723.98
Services not included in capitation:	9823.73
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation, ID Waiver, 15 Minutes		15 Minutes	2049	479.10	10.11		
Day Habilitation, ID Waiver, Per Day - FFS		Day	48	46.91	295.76	665956.88	
Day Habilitation, ID Waiver, 15 Minutes - FFS		15 Minutes	39	479.10	10.11	188904.34	
Prevocational Services Total:							1645130.56
Prevocational Service, Hour		Hour	91	575.73	7.50	392935.72	
Prevocational Service, Full Day		Full Day	103	919.10	12.72	1204168.06	
Prevocational Service, Hour - FFS		Hour	3	575.73	7.50	12953.92	
Prevocational Service, Full Day - FFS		Full Day	3	919.10	12.72	35072.86	
Residential Based Supported Community Living Total:							184774927.00
Residential Based Supported Community Living - Day		Day	1310	473.49	286.10	177459790.59	
Residential Based Supported Community Living - Day - FFS		Day	54	473.49	286.10	7315136.41	
Respite Total:							77519647.84
Respite- Homa Care Agency & Non-Facility, Group		15 Minutes	5303	619.92	4.93	16207058.30	
Respite- Homa Care Agency & Non-Facility, Basic Individual		15 Minutes	12870	629.34	5.77	46734725.47	
Respite- Homa Care Agency &		15 Minutes	54	819.03	13.40	592650.11	

GRAND TOTAL:	702755226.92
Total: Services included in capitation:	557560458.95
Total: Services not included in capitation:	145194767.97
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	47547.71
Services included in capitation:	37723.98
Services not included in capitation:	9823.73
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non-Facility, Specialized							
Respite-RCF/ID		15 Minutes	4	216.24	5.38	4653.48	
Respite-HHA Specialized		15 Minutes	8	591.48	15.75	74526.48	
Respite-Camp		15 Minutes	1098	730.51	4.43	3553302.91	
Respite-HHA Basic Individual		15 Minutes	8	877.68	7.28	51116.08	
Teen Day Camp - 13 to 21 Years Old		15 Minutes	33	800.30	5.35	141292.96	
Group Summer Day Camp - Group Recreational		15 Minutes	67	728.44	5.35	261109.32	
Respite-Nursing Facility		15 Minutes	4	559.68	5.00	11193.60	
Respite-ICF/ID		15 Minutes	13	180.91	5.29	12441.18	
Respite Resident Camp-Weeklong		15 Minutes	1445	138.10	6.77	1350983.96	
Group Specialized Summer Day Camp		15 Minutes	330	145.64	15.62	750715.94	
Respite-Homa Care Agency & Non-Facility, Group - FFS		15 Minutes	591	619.92	4.93	1806217.51	
Respite-Homa Care Agency & Non-Facility, Basic Individual - FFS		15 Minutes	1434	629.34	5.77	5207272.44	
Respite-Homa Care Agency & Non-Facility, Specialized - FFS		15 Minutes	6	819.03	13.40	65850.01	
Respite-RCF/ID - FFS		15 Minutes	1	216.24	5.38	1163.37	
Respite-HHA Specialized -						9315.81	

GRAND TOTAL:	**702755226.92**
Total: Services included in capitation:	557560458.95
Total: Services not included in capitation:	145194767.97
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**47547.71**
Services included in capitation:	37723.98
Services not included in capitation:	9823.73
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS		15 Minutes	1	591.48	15.75		
Respite-Camp - FFS		15 Minutes	122	730.51	4.43	394811.43	
Respite-HHA Basic Individual - FFS		15 Minutes	1	877.68	7.28	6389.51	
Teen Day Camp - 13 to 21 Years Old - FFS		15 Minutes	4	800.30	5.35	17126.42	
Group Summer Day Camp - Group Recreational - FFS FFS		15 Minutes	7	728.44	5.35	27280.08	
Respite- Nursing Facility - FFS		15 Minutes	1	559.68	5.00	2798.40	
Respite- ICF/ID - FFS		15 Minutes	1	180.91	5.29	957.01	
Respite Resident Camp- Weeklong - FFS		15 Minutes	161	138.10	6.77	150524.86	
Group Specialized Summer Day Camp - FFS		15 Minutes	37	145.64	15.62	84171.18	
Supported Employment Total:							15181629.49
Maintain Employment - Individual		15 Minutes	574	17.80	66.30	677400.36	
Maintain Employment - Small Group		15 Minutes	766	1083.37	2.84	2356806.43	
Long Term Job Coaching		Month	2495	4.20	1129.18	11832677.22	
Maintain Employment - Individual - FFS		15 Minutes	12	17.80	66.30	14161.68	
Maintain Employment - Small Group - FFS		15 Minutes	16	1083.37	2.84	49228.33	
Long Term Job Coaching - FFS		Month	53	4.20	1129.18	251355.47	
Home Health							36772.02

GRAND TOTAL:	702755226.92
Total: Services included in capitation:	557560458.95
Total: Services not included in capitation:	145194767.97
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	47547.71
Services included in capitation:	37723.98
Services not included in capitation:	9823.73
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Aide Services Total:							
Home Health Aide Services		Hour	2	518.50	23.64	24514.68	
Home Health Aide Services - FFS		Hour	1	518.50	23.64	12257.34	
Nursing Total:							836656.66
Nursing Care in the Home/LPN; Per Hour		Hour	20	486.14	45.29	440345.61	
Nursing Care in the Home/RN; Per Hour		Hour	6	486.14	45.29	132103.68	
Nursing Care in the Home/LPN; Per Hour - FFS		Hour	9	486.14	45.29	198155.53	
Nursing Care in the Home/RN; Per Hour - FFS		Hour	3	486.14	45.29	66051.84	
Financial Management Services Total:							14880544.75
Financial Management Services		Month	1934	94.43	70.57	12888031.14	
Financial Management Services - FFS		Month	299	94.43	70.57	1992513.60	
Independent Support Broker Total:							195786.09
Independent Support Broker		Month	1934	5.33	16.45	169570.22	
Independent Support Broker - FFS		Month	299	5.33	16.45	26215.87	
Individual Directed Goods and Services Total:							894436.19
Individual Directed Goods and Services		Month	1934	70.52	5.68	774670.66	
Individual Directed		Month				119765.53	

GRAND TOTAL:	**702755226.92**
Total: Services included in capitation:	557560458.95
Total: Services not included in capitation:	145194767.97
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**47547.71**
Services included in capitation:	37723.98
Services not included in capitation:	9823.73
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goods and Services - FFS			299	70.52	5.68		
Self Directed Community Support and Employment Total:							594777.41
Self Directed Community Support and Employment		Month	1934	20.60	12.93	515136.37	
Self Directed Community Support and Employment - FFS		Month	299	20.60	12.93	79641.04	
Self Directed Personal Care Total:							3013503.62
Self Directed Personal Care		Month	1934	27.66	48.79	2609993.73	
Self Directed Personal Care - FFS		Month	299	27.66	48.79	403509.89	
Consumer Directed Attendant Care (CDAC) - skilled Total:							4183950.21
CDAC - Agency - 15 Minutes		15 Minutes	20	4884.29	14.65	1431096.97	
CDAC - Individual - 15 Minutes		15 Minutes	30	3250.18	9.75	950677.65	
CDAC - Agency - 15 Minutes - FFS		15 Minutes	15	4884.29	14.65	1073322.73	
CDAC - Individual - 15 Minutes - FFS		15 Minutes	23	3250.18	9.75	728852.86	
Consumer Directed Attendant Care (CDAC) - unskilled Total:							5996175.41
CDAC- Agency - 15 Minutes		15 Minutes	180	695.89	5.85	732772.17	
CDAC- Individual - 15 Minutes		15 Minutes	270	2554.29	3.89	2682770.79	

GRAND TOTAL:	702755226.92
Total: Services included in capitation:	557560458.95
Total: Services not included in capitation:	145194767.97
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	47547.71
Services included in capitation:	37723.98
Services not included in capitation:	9823.73
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CDAC-Agency - 15 Minutes - FFS		15 Minutes	136	695.89	5.85	553650.08	
CDAC-Individual - 15 Minutes - FFS		15 Minutes	204	2554.29	3.89	2026982.37	
Enabling Technology for Remote Support Total:							2154890.25
1 Job (Equipment / Technology)		1 Job	600	8.00	425.00	2040000.00	
1 Job (Equipment / Technology) - FFS		1Job	33	8.00	425.00	112200.00	
1 Assessment		1 Assessment	600	1.00	4.25	2550.00	
1 Assessment - FFS		1 Assessment	33	1.00	4.25	140.25	
Home and Vehicle Modification Total:							99419.98
Home and Vehicle Modification		Occurrence	19	1.03	3860.97	75559.18	
Home and Vehicle Modification - FFS		Occurrence	6	1.03	3860.97	23860.79	
Interim Medical Monitoring and Treatment Total:							908703.62
IMMT - Nurse		15 Minutes	1	1872.27	11.57	21662.16	
IMMT - Aide or CNA		15 Minutes	14	1255.98	9.33	164056.11	
IMMT - Nurse - FFS		15 Minutes	2	1872.27	11.57	43324.33	
IMMT - Aide or CNA - FFS		15 Minutes	58	1255.98	9.33	679661.02	
Medical Day Care for Children Total:							7900200.00
Medical Day Care for Children 15 Minutes		15 Minutes	110	5600.00	8.55	5266800.00	

GRAND TOTAL:	**702755226.92**
Total: Services included in capitation:	557560458.95
Total: Services not included in capitation:	145194767.97
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**47547.71**
Services included in capitation:	37723.98
Services not included in capitation:	9823.73
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Day Care for Children 15 Minutes - FFS		15 Minutes	55	5600.00	8.55	2633400.00	
Personal Emergency Response or Portable Locator System Total:							111956.08
Personal Emergency Response- Initial		Installation	104	1.38	53.85	7728.55	
Personal Emergency Response- Ongoing		Installation	440	14.48	10.72	68299.26	
Personal Emergency Response- Initial - FFS		Installation	49	1.38	53.85	3641.34	
Personal Emergency Response- Ongoing - FFS		Installation	208	14.48	10.72	32286.92	
Supported Community Living Total:							322213977.82
Supported Community Living, Per Day		Day	3505	1047.65	7.53	27650259.77	
Supported Community Living, 15 Minutes		15 Minutes	3098	326.03	175.98	177747004.62	
Supported Community Living, Per Day - FFS		Day	1993	1047.65	7.53	15722387.37	
Supported Community Living, 15 Minutes - FFS		15 Minutes	1762	326.03	175.98	101094326.06	
Transportation Total:							9346187.22
Per Mile		Mile	834	440.94	6.49	2386658.30	
Per Trip		Trip	1785	125.10	25.96	5796958.86	
Per Mile - FFS		Mile	118	440.94	6.49	337680.67	

GRAND TOTAL:	**702755226.92**
Total: Services included in capitation:	557560458.95
Total: Services not included in capitation:	145194767.97
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**47547.71**
Services included in capitation:	37723.98
Services not included in capitation:	9823.73
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Per Trip - FFS		Trip	254	125.10	25.96	824889.38	
GRAND TOTAL:							702755226.92
Total: Services included in capitation:							557560458.95
Total: Services not included in capitation:							145194767.97
Total Estimated Unduplicated Participants:							14780
Factor D (Divide total by number of participants):							47547.71
Services included in capitation:							37723.98
Services not included in capitation:							9823.73
Average Length of Stay on the Waiver:							354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							4818141.03
Adult Day Care - 15 Minutes		15 Minutes	6	359.43	16.92	36489.33	
Adult Day Care - Full Day		Full Day	393	37.77	268.11	3979720.28	
Adult Day Care - Half Day		Half Day	254	19.71	140.03	701037.79	
Adult Day Care - 15 Minutes - FFS		15 Minutes	1	359.43	16.92	6081.56	
Adult Day Care- Full Day - FFS		Full Day	8	37.77	268.11	81012.12	
Adult Day Care - Half Day - FFS		Half Day	5	19.71	140.03	13799.96	
Day Habilitation Total:							46978863.59
Day Habilitation,		Day	2547	46.91	300.20	35867826.95	
GRAND TOTAL:							723981648.24
Total: Services included in capitation:							574421424.02
Total: Services not included in capitation:							149560224.22
Total Estimated Unduplicated Participants:							14780
Factor D (Divide total by number of participants):							48983.87
Services included in capitation:							38864.78
Services not included in capitation:							10119.10
Average Length of Stay on the Waiver:							354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ID Waiver, Per Day							
Day Habilitation, ID Waiver, 15 Minutes		15 Minutes	2080	479.10	10.26	10224377.28	
Day Habilitation, ID Waiver, Per Day - FFS		Day	49	46.91	300.20	690036.72	
Day Habilitation, ID Waiver, 15 Minutes - FFS		15 Minutes	40	479.10	10.26	196622.64	
Prevocational Services Total:							1697706.75
Prevocational Service, Hour		Hour	92	575.73	7.61	403080.09	
Prevocational Service, Full Day		Full Day	105	919.10	12.91	1245886.00	
Prevocational Service, Hour - FFS		Hour	3	575.73	7.61	13143.92	
Prevocational Service, Full Day - FFS		Full Day	3	919.10	12.91	35596.74	
Residential Based Supported Community Living Total:							190433014.12
Residential Based Supported Community Living - Day		Day	1330	473.49	290.39	182870692.26	
Residential Based Supported Community Living - Day - FFS		Day	55	473.49	290.39	7562321.86	
Respite Total:							79881284.27
Respite- Homa Care Agency & Non-Facility, Group		15 Minutes	5383	619.92	5.00	16685146.80	
Respite- Homa Care Agency & Non-Facility, Basic Individual		15 Minutes	13063	629.34	5.86	48175460.94	

GRAND TOTAL:	723981648.24
Total: Services included in capitation:	574421424.02
Total: Services not included in capitation:	149560224.22
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	48983.87
Services included in capitation:	38864.78
Services not included in capitation:	10119.10
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite-Homa Care Agency & Non-Facility, Specialized		15 Minutes	55	819.03	13.60	612634.44	
Respite-RCF/ID		15 Minutes	4	216.24	5.46	4722.68	
Respite-HHA Specialized		15 Minutes	8	591.48	15.99	75662.12	
Respite-Camp		15 Minutes	1114	730.51	4.50	3662046.63	
Respite-HHA Basic Individual		15 Minutes	8	877.68	7.39	51888.44	
Teen Day Camp - 13 to 21 Years Old		15 Minutes	33	800.30	5.43	143405.76	
Group Summer Day Camp - Group Recreational		15 Minutes	68	728.44	5.43	268969.19	
Respite-Nursing Facility		15 Minutes	4	559.68	5.08	11372.70	
Respite-ICF/ID		15 Minutes	13	180.91	5.37	12629.33	
Respite Resident Camp-Weeklong		15 Minutes	1467	138.10	6.87	1391811.85	
Group Specialized Summer Day Camp		15 Minutes	335	145.64	15.85	773311.99	
Respite-Homa Care Agency & Non-Facility, Group - FFS		15 Minutes	600	619.92	5.00	1859760.00	
Respite-Homa Care Agency & Non-Facility, Basic Individual - FFS		15 Minutes	1456	629.34	5.86	5369629.57	
Respite-Homa Care Agency & Non-Facility, Specialized - FFS		15 Minutes	6	819.03	13.60	66832.85	
Respite-RCF/ID -		15 Minutes	1	216.24	5.46	1180.67	
GRAND TOTAL:							**723981648.24**
Total: Services included in capitation:							574421424.02
Total: Services not included in capitation:							149560224.22
Total Estimated Unduplicated Participants:							**14780**
Factor D (Divide total by number of participants):							**48983.87**
Services included in capitation:							38864.78
Services not included in capitation:							10119.10
Average Length of Stay on the Waiver:							354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS							
Respite-HHA Specialized - FFS		15 Minutes	1	591.48	15.99	9457.77	
Respite-Camp - FFS		15 Minutes	124	730.51	4.50	407624.58	
Respite-HHA Basic Individual - FFS		15 Minutes	1	877.68	7.39	6486.06	
Teen Day Camp - 13 to 21 Years Old - FFS		15 Minutes	4	800.30	5.43	17382.52	
Group Summer Day Camp - Group Recreational - FFS FFS		15 Minutes	7	728.44	5.43	27688.00	
Respite-Nursing Facility - FFS		15 Minutes	1	559.68	5.08	2843.17	
Respite-ICF/ID - FFS		15 Minutes	1	180.91	5.37	971.49	
Respite Resident Camp-Weeklong - FFS		15 Minutes	163	138.10	6.87	154645.76	
Group Specialized Summer Day Camp - FFS		15 Minutes	38	145.64	15.85	87718.97	
Supported Employment Total:							15635150.67
Maintain Employment - Individual		15 Minutes	583	17.80	67.29	698295.25	
Maintain Employment - Small Group		15 Minutes	777	1083.37	2.88	2424322.05	
Long Term Job Coaching		Month	2532	4.20	1146.12	12188298.53	
Maintain Employment - Individual - FFS		15 Minutes	12	17.80	67.29	14373.14	
Maintain Employment - Small Group - FFS		15 Minutes	16	1083.37	2.88	49921.69	
Long Term Job Coaching						259940.02	

GRAND TOTAL:	**723981648.24**
Total: Services included in capitation:	574421424.02
Total: Services not included in capitation:	149560224.22
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**48983.87**
Services included in capitation:	38864.78
Services not included in capitation:	10119.10
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
- FFS		Month	54	4.20	1146.12		
Home Health Aide Services Total:							**37316.44**
Home Health Aide Services		Hour	2	518.50	23.99	24877.63	
Home Health Aide Services - FFS		Hour	1	518.50	23.99	12438.82	
Nursing Total:							**849218.52**
Nursing Care in the Home/LPN; Per Hour		Hour	20	486.14	45.97	446957.12	
Nursing Care in the Home/RN; Per Hour		Hour	6	486.14	45.97	134087.13	
Nursing Care in the Home/LPN; Per Hour - FFS		Hour	9	486.14	45.97	201130.70	
Nursing Care in the Home/RN; Per Hour - FFS		Hour	3	486.14	45.97	67043.57	
Financial Management Services Total:							**15327271.36**
Financial Management Services		Month	1963	94.43	71.63	13277773.03	
Financial Management Services - FFS		Month	303	94.43	71.63	2049498.33	
Independent Support Broker Total:							**201698.93**
Independent Support Broker		Month	1963	5.33	16.70	174728.59	
Independent Support Broker - FFS		Month	303	5.33	16.70	26970.33	
Individual Directed Goods and Services Total:							**922036.31**
Individual Directed Goods and		Month	1963	70.52	5.77	798745.49	

GRAND TOTAL:	**723981648.24**
Total: Services included in capitation:	574421424.02
Total: Services not included in capitation:	149560224.22
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**48983.87**
Services included in capitation:	38864.78
Services not included in capitation:	10119.10
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services							
Individual Directed Goods and Services - FFS		Month	303	70.52	5.77	123290.82	
Self Directed Community Support and Employment Total:							612436.35
Self Directed Community Support and Employment		Month	1963	20.60	13.12	530543.94	
Self Directed Community Support and Employment - FFS		Month	303	20.60	13.12	81892.42	
Self Directed Personal Care Total:							3103792.77
Self Directed Personal Care		Month	1963	27.66	49.52	2688766.64	
Self Directed Personal Care - FFS		Month	303	27.66	49.52	415026.13	
Consumer Directed Attendant Care (CDAC) - skilled Total:							4247398.18
CDAC - Agency - 15 Minutes		15 Minutes	20	4884.29	14.87	1452587.85	
CDAC - Individual - 15 Minutes		15 Minutes	30	3250.18	9.90	965303.46	
CDAC - Agency - 15 Minutes - FFS		15 Minutes	15	4884.29	14.87	1089440.88	
CDAC - Individual - 15 Minutes - FFS		15 Minutes	23	3250.18	9.90	740065.99	
Consumer Directed Attendant Care (CDAC) - unskilled Total:							6179904.58
CDAC- Agency - 15 Minutes		15 Minutes	183	695.89	5.94	756446.35	

GRAND TOTAL:	723981648.24
Total: Services included in capitation:	574421424.02
Total: Services not included in capitation:	149560224.22
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	48983.87
Services included in capitation:	38864.78
Services not included in capitation:	10119.10
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CDAC-Individual - 15 Minutes		15 Minutes	274	2554.29	3.95	2764508.07	
CDAC-Agency - 15 Minutes - FFS		15 Minutes	138	695.89	5.94	570434.95	
CDAC-Individual - 15 Minutes - FFS		15 Minutes	207	2554.29	3.95	2088515.22	
Enabling Technology for Remote Support Total:							2218334.70
1 Job (Equipment / Technology)		1 Job	609	8.00	431.38	2101683.36	
1 Job (Equipment / Technology) - FFS		1Job	33	8.00	431.38	113884.32	
1 Assessment		1 Assessment	609	1.00	4.31	2624.79	
1 Assessment - FFS		1 Assessment	33	1.00	4.31	142.23	
Home and Vehicle Modification Total:							100911.16
Home and Vehicle Modification		Occurrence	19	1.03	3918.88	76692.48	
Home and Vehicle Modification - FFS		Occurrence	6	1.03	3918.88	24218.68	
Interim Medical Monitoring and Treatment Total:							934212.88
IMMT - Nurse		15 Minutes	1	1872.27	11.74	21980.45	
IMMT - Aide or CNA		15 Minutes	14	1255.98	9.47	166517.83	
IMMT - Nurse - FFS		15 Minutes	2	1872.27	11.74	43960.90	
IMMT - Aide or CNA - FFS		15 Minutes	59	1255.98	9.47	701753.71	
Medical Day Care for Children Total:							8166144.00
Medical Day Care for		15 Minutes				5444096.00	

GRAND TOTAL:	723981648.24
Total: Services included in capitation:	574421424.02
Total: Services not included in capitation:	149560224.22
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	48983.87
Services included in capitation:	38864.78
Services not included in capitation:	10119.10
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Children 15 Minutes			112	5600.00	8.68		
Medical Day Care for Children 15 Minutes - FFS		15 Minutes	56	5600.00	8.68	2722048.00	
Personal Emergency Response or Portable Locator System Total:							115430.10
Personal Emergency Response-Initial		Installation	106	1.38	54.66	7995.66	
Personal Emergency Response-Ongoing		Installation	447	14.48	10.88	70421.45	
Personal Emergency Response-Initial - FFS		Installation	50	1.38	54.66	3771.54	
Personal Emergency Response-Ongoing - FFS		Installation	211	14.48	10.88	33241.45	
Supported Community Living Total:							331887961.18
Supported Community Living, Per Day		Day	3558	1047.65	7.64	28478395.67	
Supported Community Living, 15 Minutes		15 Minutes	3144	326.03	178.62	183092344.72	
Supported Community Living, Per Day - FFS		Day	2023	1047.65	7.64	16192185.06	
Supported Community Living, 15 Minutes - FFS		15 Minutes	1788	326.03	178.62	104125035.74	
Transportation Total:							9633420.33
Per Mile		Mile	847	440.94	6.59	2461208.03	
Per Trip		Trip	1812	125.10	26.35	5973049.62	

GRAND TOTAL:	**723981648.24**
Total: Services included in capitation:	574421424.02
Total: Services not included in capitation:	149560224.22
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**48983.87**
Services included in capitation:	38864.78
Services not included in capitation:	10119.10
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Per Mile - FFS		Mile	120	440.94	6.59	348695.35	
Per Trip - FFS		Trip	258	125.10	26.35	850467.33	

GRAND TOTAL:	723981648.24
Total: Services included in capitation:	574421424.02
Total: Services not included in capitation:	149560224.22
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	48983.87
Services included in capitation:	38864.78
Services not included in capitation:	10119.10
Average Length of Stay on the Waiver:	354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							4963251.93
Adult Day Care - 15 Minutes		15 Minutes	6	359.43	17.17	37028.48	
Adult Day Care - Full Day		Full Day	399	37.77	272.13	4101061.69	
Adult Day Care - Half Day		Half Day	258	19.71	142.13	722756.63	
Adult Day Care - 15 Minutes - FFS		15 Minutes	1	359.43	17.17	6171.41	
Adult Day Care- Full Day - FFS		Full Day	8	37.77	272.13	82226.80	
Adult Day Care - Half Day - FFS		Half Day	5	19.71	142.13	14006.91	
Day Habilitation Total:							48396263.41

GRAND TOTAL:	745845070.03
Total: Services included in capitation:	591756129.00
Total: Services not included in capitation:	154088941.03
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	50463.13
Services included in capitation:	40037.63
Services not included in capitation:	10425.50
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation, ID Waiver, Per Day		Day	2585	46.91	304.70	36948638.04	
Day Habilitation, ID Waiver, 15 Minutes		15 Minutes	2111	479.10	10.41	10528466.84	
Day Habilitation, ID Waiver, Per Day - FFS		Day	50	46.91	304.70	714673.85	
Day Habilitation, ID Waiver, 15 Minutes - FFS		15 Minutes	41	479.10	10.41	204484.67	
Prevocational Services Total:							1751108.12
Prevocational Service, Hour		Hour	93	575.73	7.72	413351.11	
Prevocational Service, Full Day		Full Day	107	919.10	13.10	1288302.47	
Prevocational Service, Hour - FFS		Hour	3	575.73	7.72	13333.91	
Prevocational Service, Full Day - FFS		Full Day	3	919.10	13.10	36120.63	
Residential Based Supported Community Living Total:							196223015.56
Residential Based Supported Community Living - Day		Day	1350	473.49	294.75	188407589.62	
Residential Based Supported Community Living - Day - FFS		Day	56	473.49	294.75	7815425.94	
Respite Total:							82334265.11
Respite- Homa Care Agency & Non-Facility, Group		15 Minutes	5464	619.92	5.08	17207193.83	
Respite- Homa Care Agency & Non-Facility,		15 Minutes	13259	629.34	5.95	49649293.41	

GRAND TOTAL:	745845070.03
Total: Services included in capitation:	591756129.00
Total: Services not included in capitation:	154088941.03
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	50463.13
Services included in capitation:	40037.63
Services not included in capitation:	10425.50
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Basic Individual							
Respite- Homa Care Agency & Non-Facility, Specialized		15 Minutes	56	819.03	13.80	632946.38	
Respite- RCF/ID		15 Minutes	4	216.24	5.54	4791.88	
Respite-HHA Specialized		15 Minutes	8	591.48	16.23	76797.76	
Respite-Camp		15 Minutes	1131	730.51	4.57	3775765.12	
Respite-HHA Basic Individual		15 Minutes	8	877.68	7.50	52660.80	
Teen Day Camp - 13 to 21 Years Old		15 Minutes	33	800.30	5.51	145518.55	
Group Summer Day Camp - Group Recreational		15 Minutes	69	728.44	5.51	276945.60	
Respite- Nursing Facility		15 Minutes	4	559.68	5.16	11551.80	
Respite- ICF/ID		15 Minutes	13	180.91	5.45	12817.47	
Respite Resident Camp- Weeklong		15 Minutes	1489	138.10	6.97	1433247.37	
Group Specialized Summer Day Camp		15 Minutes	340	145.64	16.09	796738.18	
Respite- Homa Care Agency & Non-Facility, Group - FFS		15 Minutes	609	619.92	5.08	1917858.90	
Respite- Homa Care Agency & Non-Facility, Basic Individual - FFS		15 Minutes	1478	629.34	5.95	5534478.89	
Respite- Homa Care Agency & Non-Facility, Specialized - FFS		15 Minutes	6	819.03	13.80	67815.68	

GRAND TOTAL:	**745845070.03**
Total: Services included in capitation:	591756129.00
Total: Services not included in capitation:	154088941.03
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**50463.13**
Services included in capitation:	40037.63
Services not included in capitation:	10425.50
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite-RCF/ID - FFS		15 Minutes	1	216.24	5.54	1197.97	
Respite-HHA Specialized - FFS		15 Minutes	1	591.48	16.23	9599.72	
Respite-Camp - FFS		15 Minutes	126	730.51	4.57	420642.27	
Respite-HHA Basic Individual - FFS		15 Minutes	1	877.68	7.50	6582.60	
Teen Day Camp - 13 to 21 Years Old - FFS		15 Minutes	4	800.30	5.51	17638.61	
Group Summer Day Camp - Group Recreational - FFS FFS		15 Minutes	7	728.44	5.51	28095.93	
Respite-Nursing Facility - FFS		15 Minutes	1	559.68	5.16	2887.95	
Respite-ICF/ID - FFS		15 Minutes	1	180.91	5.45	985.96	
Respite Resident Camp-Weeklong - FFS		15 Minutes	165	138.10	6.97	158821.90	
Group Specialized Summer Day Camp - FFS		15 Minutes	39	145.64	16.09	91390.56	
Supported Employment Total:							16106369.23
Maintain Employment - Individual		15 Minutes	592	17.80	68.30	719718.08	
Maintain Employment - Small Group		15 Minutes	789	1083.37	2.92	2495954.48	
Long Term Job Coaching		Month	2570	4.20	1163.31	12556768.14	
Maintain Employment - Individual - FFS		15 Minutes	12	17.80	68.30	14588.88	
Maintain Employment - Small Group - FFS		15 Minutes	16	1083.37	2.92	50615.05	

GRAND TOTAL:	745845070.03
Total: Services included in capitation:	591756129.00
Total: Services not included in capitation:	154088941.03
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	50463.13
Services included in capitation:	40037.63
Services not included in capitation:	10425.50
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Long Term Job Coaching - FFS		Month	55	4.20	1163.31	268724.61	
Home Health Aide Services Total:							37876.43
Home Health Aide Services		Hour	2	518.50	24.35	25250.95	
Home Health Aide Services - FFS		Hour	1	518.50	24.35	12625.48	
Nursing Total:							861965.11
Nursing Care in the Home/LPN; Per Hour		Hour	20	486.14	46.66	453665.85	
Nursing Care in the Home/RN; Per Hour		Hour	6	486.14	46.66	136099.75	
Nursing Care in the Home/LPN; Per Hour - FFS		Hour	9	486.14	46.66	204149.63	
Nursing Care in the Home/RN; Per Hour - FFS		Hour	3	486.14	46.66	68049.88	
Financial Management Services Total:							15789640.30
Financial Management Services		Month	1992	94.43	72.70	13675201.51	
Financial Management Services - FFS		Month	308	94.43	72.70	2114438.79	
Independent Support Broker Total:							207790.05
Independent Support Broker		Month	1992	5.33	16.95	179964.25	
Independent Support Broker - FFS		Month	308	5.33	16.95	27825.80	
Individual Directed Goods and Services Total:							950468.56
Individual Directed		Month				823188.42	

GRAND TOTAL:	745845070.03
Total: Services included in capitation:	591756129.00
Total: Services not included in capitation:	154088941.03
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	50463.13
Services included in capitation:	40037.63
Services not included in capitation:	10425.50
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goods and Services			1992	70.52	5.86		
Individual Directed Goods and Services - FFS		Month	308	70.52	5.86	127280.14	
Self Directed Community Support and Employment Total:							631101.60
Self Directed Community Support and Employment		Month	1992	20.60	13.32	546588.86	
Self Directed Community Support and Employment - FFS		Month	308	20.60	13.32	84512.74	
Self Directed Personal Care Total:							3197440.68
Self Directed Personal Care		Month	1992	27.66	50.26	2769261.67	
Self Directed Personal Care - FFS		Month	308	27.66	50.26	428179.01	
Consumer Directed Attendant Care (CDAC) - skilled Total:							4310846.14
CDAC - Agency - 15 Minutes		15 Minutes	20	4884.29	15.09	1474078.72	
CDAC - Individual - 15 Minutes		15 Minutes	30	3250.18	10.05	979929.27	
CDAC - Agency - 15 Minutes - FFS		15 Minutes	15	4884.29	15.09	1105559.04	
CDAC - Individual - 15 Minutes - FFS		15 Minutes	23	3250.18	10.05	751279.11	
Consumer Directed Attendant Care (CDAC) - unskilled Total:							6366405.66
CDAC- Agency - 15 Minutes		15 Minutes	186	695.89	6.03	780496.31	

GRAND TOTAL:	**745845070.03**
Total: Services included in capitation:	591756129.00
Total: Services not included in capitation:	154088941.03
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**50463.13**
Services included in capitation:	40037.63
Services not included in capitation:	10425.50
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CDAC- Individual - 15 Minutes		15 Minutes	278	2554.29	4.01	2847471.41	
CDAC- Agency - 15 Minutes - FFS		15 Minutes	140	695.89	6.03	587470.34	
CDAC- Individual - 15 Minutes - FFS		15 Minutes	210	2554.29	4.01	2150967.61	
Enabling Technology for Remote Support Total:							2283167.67
1 Job (Equipment / Technology)		1 Job	618	8.00	437.85	2164730.40	
1 Job (Equipment / Technology) - FFS		1Job	33	8.00	437.85	115592.40	
1 Assessment		1 Assessment	618	1.00	4.37	2700.66	
1 Assessment - FFS		1 Assessment	33	1.00	4.37	144.21	
Home and Vehicle Modification Total:							102424.75
Home and Vehicle Modification		Occurrence	19	1.03	3977.66	77842.81	
Home and Vehicle Modification - FFS		Occurrence	6	1.03	3977.66	24581.94	
Interim Medical Monitoring and Treatment Total:							960129.99
IMMT - Nurse		15 Minutes	1	1872.27	11.92	22317.46	
IMMT - Aide or CNA		15 Minutes	14	1255.98	9.61	168979.55	
IMMT - Nurse - FFS		15 Minutes	2	1872.27	11.92	44634.92	
IMMT - Aide or CNA - FFS		15 Minutes	60	1255.98	9.61	724198.07	
Medical Day Care for Children Total:							8436456.00
Medical Day Care for		15 Minutes				5624304.00	

GRAND TOTAL:	**745845070.03**
Total: Services included in capitation:	591756129.00
Total: Services not included in capitation:	154088941.03
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**50463.13**
Services included in capitation:	40037.63
Services not included in capitation:	10425.50
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Children 15 Minutes			114	5600.00	8.81		
Medical Day Care for Children 15 Minutes - FFS		15 Minutes	57	5600.00	8.81	2812152.00	
Personal Emergency Response or Portable Locator System Total:							118959.37
Personal Emergency Response-Initial		Installation	108	1.38	55.48	8268.74	
Personal Emergency Response-Ongoing		Installation	454	14.48	11.04	72576.08	
Personal Emergency Response-Initial - FFS		Installation	51	1.38	55.48	3904.68	
Personal Emergency Response-Ongoing - FFS		Installation	214	14.48	11.04	34209.87	
Supported Community Living Total:							341888494.83
Supported Community Living, Per Day		Day	3611	1047.65	7.75	29318747.16	
Supported Community Living, 15 Minutes		15 Minutes	3191	326.03	181.30	188617581.65	
Supported Community Living, Per Day - FFS		Day	2053	1047.65	7.75	16668897.24	
Supported Community Living, 15 Minutes - FFS		15 Minutes	1815	326.03	181.30	107283268.78	
Transportation Total:							9927629.53
Per Mile		Mile	860	440.94	6.69	2536904.20	
Per Trip		Trip	1839	125.10	26.75	6154075.58	

GRAND TOTAL:	745845070.03
Total: Services included in capitation:	591756129.00
Total: Services not included in capitation:	154088941.03
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	50463.13
Services included in capitation:	40037.63
Services not included in capitation:	10425.50
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Per Mile - FFS		Mile	122	440.94	6.69	359886.41	
Per Trip - FFS		Trip	262	125.10	26.75	876763.35	
GRAND TOTAL:							745845070.03
Total: Services included in capitation:							591756129.00
Total: Services not included in capitation:							154088941.03
Total Estimated Unduplicated Participants:							14780
Factor D (Divide total by number of participants):							50463.13
Services included in capitation:							40037.63
Services not included in capitation:							10425.50
Average Length of Stay on the Waiver:							354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							5111634.95
Adult Day Care - 15 Minutes		15 Minutes	6	359.43	17.43	37589.19	
Adult Day Care - Full Day		Full Day	405	37.77	276.21	4225142.94	
Adult Day Care - Half Day		Half Day	262	19.71	144.26	744961.53	
Adult Day Care - 15 Minutes - FFS		15 Minutes	1	359.43	17.43	6264.86	
Adult Day Care- Full Day - FFS		Full Day	8	37.77	276.21	83459.61	
Adult Day Care - Half Day - FFS		Half Day	5	19.71	144.26	14216.82	
Day Habilitation Total:							49873544.09
GRAND TOTAL:							768362030.56
Total: Services included in capitation:							609619020.17
Total: Services not included in capitation:							158743010.39
Total Estimated Unduplicated Participants:							14780
Factor D (Divide total by number of participants):							51986.61
Services included in capitation:							41246.21
Services not included in capitation:							10740.39
Average Length of Stay on the Waiver:							354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation, ID Waiver, Per Day		Day	2624	46.91	309.27	38068613.36	
Day Habilitation, ID Waiver, 15 Minutes		15 Minutes	2143	479.10	10.57	10852338.44	
Day Habilitation, ID Waiver, Per Day - FFS		Day	51	46.91	309.27	739900.64	
Day Habilitation, ID Waiver, 15 Minutes - FFS		15 Minutes	42	479.10	10.57	212691.65	
Prevocational Services Total:							1806922.51
Prevocational Service, Hour		Hour	94	575.73	7.84	424289.98	
Prevocational Service, Full Day		Full Day	109	919.10	13.30	1332419.27	
Prevocational Service, Hour - FFS		Hour	3	575.73	7.84	13541.17	
Prevocational Service, Full Day - FFS		Full Day	3	919.10	13.30	36672.09	
Residential Based Supported Community Living Total:							202140262.71
Residential Based Supported Community Living - Day		Day	1370	473.49	299.17	194065984.52	
Residential Based Supported Community Living - Day - FFS		Day	57	473.49	299.17	8074278.19	
Respite Total:							84839456.17
Respite-Homa Care Agency & Non-Facility, Group		15 Minutes	5546	619.92	5.16	17740473.81	
Respite-Homa Care Agency & Non-Facility,		15 Minutes	13458	629.34	6.04	51156732.63	

GRAND TOTAL:	768362030.56
Total: Services included in capitation:	609619020.17
Total: Services not included in capitation:	158743010.39
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	51986.61
Services included in capitation:	41246.21
Services not included in capitation:	10740.39
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Basic Individual							
Respite-Homa Care Agency & Non-Facility, Specialized		15 Minutes	57	819.03	14.01	654052.79	
Respite-RCF/ID		15 Minutes	4	216.24	5.62	4861.08	
Respite-HHA Specialized		15 Minutes	8	591.48	16.47	77933.40	
Respite-Camp		15 Minutes	1148	730.51	4.64	3891222.23	
Respite-HHA Basic Individual		15 Minutes	8	877.68	7.61	53433.16	
Teen Day Camp - 13 to 21 Years Old		15 Minutes	33	800.30	5.59	147631.34	
Group Summer Day Camp - Group Recreational		15 Minutes	70	728.44	5.59	285038.57	
Respite-Nursing Facility		15 Minutes	4	559.68	5.24	11730.89	
Respite-ICF/ID		15 Minutes	13	180.91	5.53	13005.62	
Respite Resident Camp-Weeklong		15 Minutes	1511	138.10	7.07	1475290.54	
Group Specialized Summer Day Camp		15 Minutes	345	145.64	16.33	820513.91	
Respite-Homa Care Agency & Non-Facility, Group - FFS		15 Minutes	618	619.92	5.16	1976850.49	
Respite-Homa Care Agency & Non-Facility, Basic Individual - FFS		15 Minutes	1500	629.34	6.04	5701820.40	
Respite-Homa Care Agency & Non-Facility, Specialized - FFS		15 Minutes	6	819.03	14.01	68847.66	
GRAND TOTAL:							**768362030.56**
Total: Services included in capitation:							609619020.17
Total: Services not included in capitation:							158743010.39
Total Estimated Unduplicated Participants:							**14780**
Factor D (Divide total by number of participants):							**51986.61**
Services included in capitation:							41246.21
Services not included in capitation:							10740.39
Average Length of Stay on the Waiver:							354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite-RCF/ID - FFS		15 Minutes	1	216.24	5.62	1215.27	
Respite-HHA Specialized - FFS		15 Minutes	1	591.48	16.47	9741.68	
Respite-Camp - FFS		15 Minutes	128	730.51	4.64	433864.50	
Respite-HHA Basic Individual - FFS		15 Minutes	1	877.68	7.61	6679.14	
Teen Day Camp - 13 to 21 Years Old - FFS		15 Minutes	4	800.30	5.59	17894.71	
Group Summer Day Camp - Group Recreational - FFS FFS		15 Minutes	7	728.44	5.59	28503.86	
Respite-Nursing Facility - FFS		15 Minutes	1	559.68	5.24	2932.72	
Respite-ICF/ID - FFS		15 Minutes	1	180.91	5.53	1000.43	
Respite Resident Camp-Weeklong - FFS		15 Minutes	167	138.10	7.07	163053.29	
Group Specialized Summer Day Camp - FFS		15 Minutes	40	145.64	16.33	95132.05	
Supported Employment Total:							**16592560.27**
Maintain Employment - Individual		15 Minutes	601	17.80	69.32	741571.50	
Maintain Employment - Small Group		15 Minutes	801	1083.37	2.96	2568626.94	
Long Term Job Coaching		Month	2609	4.20	1180.76	12938531.93	
Maintain Employment - Individual - FFS		15 Minutes	12	17.80	69.32	14806.75	
Maintain Employment - Small Group - FFS		15 Minutes	16	1083.37	2.96	51308.40	

GRAND TOTAL:	**768362030.56**
Total: Services included in capitation:	609619020.17
Total: Services not included in capitation:	158743010.39
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**51986.61**
Services included in capitation:	41246.21
Services not included in capitation:	10740.39
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Long Term Job Coaching - FFS		Month	56	4.20	1180.76	277714.75	
Home Health Aide Services Total:							38451.96
Home Health Aide Services		Hour	2	518.50	24.72	25634.64	
Home Health Aide Services - FFS		Hour	1	518.50	24.72	12817.32	
Nursing Total:							874896.44
Nursing Care in the Home/LPN; Per Hour		Hour	20	486.14	47.36	460471.81	
Nursing Care in the Home/RN; Per Hour		Hour	6	486.14	47.36	138141.54	
Nursing Care in the Home/LPN; Per Hour - FFS		Hour	9	486.14	47.36	207212.31	
Nursing Care in the Home/RN; Per Hour - FFS		Hour	3	486.14	47.36	69070.77	
Financial Management Services Total:							16270255.95
Financial Management Services		Month	2022	94.43	73.79	14089275.17	
Financial Management Services - FFS		Month	313	94.43	73.79	2180980.78	
Independent Support Broker Total:							214063.46
Independent Support Broker		Month	2022	5.33	17.20	185368.87	
Independent Support Broker - FFS		Month	313	5.33	17.20	28694.59	
Individual Directed Goods and Services Total:							979751.99
Individual Directed		Month				848419.07	

GRAND TOTAL:	768362030.56
Total: Services included in capitation:	609619020.17
Total: Services not included in capitation:	158743010.39
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	51986.61
Services included in capitation:	41246.21
Services not included in capitation:	10740.39
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goods and Services			2022	70.52	5.95		
Individual Directed Goods and Services - FFS		Month	313	70.52	5.95	131332.92	
Self Directed Community Support and Employment Total:							650325.52
Self Directed Community Support and Employment		Month	2022	20.60	13.52	563151.26	
Self Directed Community Support and Employment - FFS		Month	313	20.60	13.52	87174.26	
Self Directed Personal Care Total:							3294536.96
Self Directed Personal Care		Month	2022	27.66	51.01	2852913.81	
Self Directed Personal Care - FFS		Month	313	27.66	51.01	441623.16	
Consumer Directed Attendant Care (CDAC) - skilled Total:							4376003.61
CDAC - Agency - 15 Minutes		15 Minutes	20	4884.29	15.32	1496546.46	
CDAC - Individual - 15 Minutes		15 Minutes	30	3250.18	10.20	994555.08	
CDAC - Agency - 15 Minutes - FFS		15 Minutes	15	4884.29	15.32	1122409.84	
CDAC - Individual - 15 Minutes - FFS		15 Minutes	23	3250.18	10.20	762492.23	
Consumer Directed Attendant Care (CDAC) - unskilled Total:							6555678.64
CDAC- Agency - 15 Minutes		15 Minutes	189	695.89	6.12	804922.05	

GRAND TOTAL:	768362030.56
Total: Services included in capitation:	609619020.17
Total: Services not included in capitation:	158743010.39
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	51986.61
Services included in capitation:	41246.21
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Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CDAC- Individual - 15 Minutes		15 Minutes	282	2554.29	4.07	2931660.80	
CDAC- Agency - 15 Minutes - FFS		15 Minutes	142	695.89	6.12	604756.25	
CDAC- Individual - 15 Minutes - FFS		15 Minutes	213	2554.29	4.07	2214339.54	
Enabling Technology for Remote Support Total:							2349468.00
1 Job (Equipment / Technology)		1 Job	627	8.00	444.42	2229210.72	
1 Job (Equipment / Technology) - FFS		1Job	33	8.00	444.42	117326.88	
1 Assessment		1 Assessment	627	1.00	4.44	2783.88	
1 Assessment - FFS		1 Assessment	33	1.00	4.44	146.52	
Home and Vehicle Modification Total:							103960.99
Home and Vehicle Modification		Occurrence	19	1.03	4037.32	79010.35	
Home and Vehicle Modification - FFS		Occurrence	6	1.03	4037.32	24950.64	
Interim Medical Monitoring and Treatment Total:							986398.78
IMMT - Nurse		15 Minutes	1	1872.27	12.10	22654.47	
IMMT - Aide or CNA		15 Minutes	14	1255.98	9.75	171441.27	
IMMT - Nurse - FFS		15 Minutes	2	1872.27	12.10	45308.93	
IMMT - Aide or CNA - FFS		15 Minutes	61	1255.98	9.75	746994.10	
Medical Day Care for Children Total:							8711136.00
Medical Day Care for		15 Minutes				5807424.00	

GRAND TOTAL:	**768362030.56**
Total: Services included in capitation:	609619020.17
Total: Services not included in capitation:	158743010.39
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**51986.61**
Services included in capitation:	41246.21
Services not included in capitation:	10740.39
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Children 15 Minutes			116	5600.00	8.94		
Medical Day Care for Children 15 Minutes - FFS		15 Minutes	58	5600.00	8.94	2903712.00	
Personal Emergency Response or Portable Locator System Total:							122642.17
Personal Emergency Response-Initial		Installation	110	1.38	56.31	8547.86	
Personal Emergency Response-Ongoing		Installation	461	14.48	11.21	74829.89	
Personal Emergency Response-Initial - FFS		Installation	52	1.38	56.31	4040.81	
Personal Emergency Response-Ongoing - FFS		Installation	217	14.48	11.21	35223.61	
Supported Community Living Total:							352240418.91
Supported Community Living, Per Day		Day	3665	1047.65	7.87	30217945.16	
Supported Community Living, 15 Minutes		15 Minutes	3239	326.03	184.02	194327175.50	
Supported Community Living, Per Day - FFS		Day	2084	1047.65	7.87	17182591.46	
Supported Community Living, 15 Minutes - FFS		15 Minutes	1842	326.03	184.02	110512706.79	
Transportation Total:							10229660.50
Per Mile		Mile	873	440.94	6.79	2613746.81	
Per Trip		Trip	1867	125.10	27.15	6341200.16	

GRAND TOTAL:	**768362030.56**
Total: Services included in capitation:	609619020.17
Total: Services not included in capitation:	158743010.39
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**51986.61**
Services included in capitation:	41246.21
Services not included in capitation:	10740.39
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Per Mile - FFS		Mile	124	440.94	6.79	371253.84	
Per Trip - FFS		Trip	266	125.10	27.15	903459.69	
GRAND TOTAL:							768362030.56
Total: Services included in capitation:							609619020.17
Total: Services not included in capitation:							158743010.39
Total Estimated Unduplicated Participants:							14780
Factor D (Divide total by number of participants):							51986.61
Services included in capitation:							41246.21
Services not included in capitation:							10740.39
Average Length of Stay on the Waiver:							354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							5263312.84
Adult Day Care - 15 Minutes		15 Minutes	6	359.43	17.69	38149.90	
Adult Day Care - Full Day		Full Day	411	37.77	280.35	4352004.81	
Adult Day Care - Half Day		Half Day	266	19.71	146.42	767659.56	
Adult Day Care - 15 Minutes - FFS		15 Minutes	1	359.43	17.69	6358.32	
Adult Day Care- Full Day - FFS		Full Day	8	37.77	280.35	84710.56	
Adult Day Care - Half Day - FFS		Half Day	5	19.71	146.42	14429.69	
Day Habilitation Total:							51381949.62
GRAND TOTAL:							791649595.45
Total: Services included in capitation:							628088738.54
Total: Services not included in capitation:							163560856.91
Total Estimated Unduplicated Participants:							14780
Factor D (Divide total by number of participants):							53562.22
Services included in capitation:							42495.86
Services not included in capitation:							11066.36
Average Length of Stay on the Waiver:							354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation, ID Waiver, Per Day		Day	2663	46.91	313.91	39214054.70	
Day Habilitation, ID Waiver, 15 Minutes		15 Minutes	2175	479.10	10.73	11181116.02	
Day Habilitation, ID Waiver, Per Day - FFS		Day	52	46.91	313.91	765726.94	
Day Habilitation, ID Waiver, 15 Minutes - FFS		15 Minutes	43	479.10	10.73	221051.95	
Prevocational Services Total:							1863610.36
Prevocational Service, Hour		Hour	95	575.73	7.96	435367.03	
Prevocational Service, Full Day		Full Day	111	919.10	13.50	1377271.35	
Prevocational Service, Hour - FFS		Hour	3	575.73	7.96	13748.43	
Prevocational Service, Full Day - FFS		Full Day	3	919.10	13.50	37223.55	
Residential Based Supported Community Living Total:							208337181.46
Residential Based Supported Community Living - Day		Day	1391	473.49	303.66	199997943.00	
Residential Based Supported Community Living - Day - FFS		Day	58	473.49	303.66	8339238.46	
Respite Total:							87405261.03
Respite- Homa Care Agency & Non-Facility, Group		15 Minutes	5629	619.92	5.24	18285135.52	
Respite- Homa Care Agency & Non-Facility,		15 Minutes	13660	629.34	6.13	52698288.37	

GRAND TOTAL:	791649595.45
Total: Services included in capitation:	628088738.54
Total: Services not included in capitation:	163560856.91
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	53562.22
Services included in capitation:	42495.86
Services not included in capitation:	11066.36
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Basic Individual							
Respite- Homa Care Agency & Non-Facility, Specialized		15 Minutes	58	819.03	14.22	675503.18	
Respite- RCF/ID		15 Minutes	4	216.24	5.70	4930.27	
Respite-HHA Specialized		15 Minutes	8	591.48	16.72	79116.36	
Respite-Camp		15 Minutes	1165	730.51	4.71	4008417.95	
Respite-HHA Basic Individual		15 Minutes	8	877.68	7.72	54205.52	
Teen Day Camp - 13 to 21 Years Old		15 Minutes	33	800.30	5.67	149744.13	
Group Summer Day Camp - Group Recreational		15 Minutes	71	728.44	5.67	293248.09	
Respite- Nursing Facility		15 Minutes	4	559.68	5.32	11909.99	
Respite- ICF/ID		15 Minutes	13	180.91	5.61	13193.77	
Respite Resident Camp- Weeklong		15 Minutes	1534	138.10	7.18	1521049.97	
Group Specialized Summer Day Camp		15 Minutes	350	145.64	16.57	844639.18	
Respite- Homa Care Agency & Non-Facility, Group - FFS		15 Minutes	627	619.92	5.24	2036734.76	
Respite- Homa Care Agency & Non-Facility, Basic Individual - FFS		15 Minutes	1523	629.34	6.13	5875511.95	
Respite- Homa Care Agency & Non-Facility, Specialized - FFS		15 Minutes	6	819.03	14.22	69879.64	

GRAND TOTAL:	**791649595.45**
Total: Services included in capitation:	628088738.54
Total: Services not included in capitation:	163560856.91
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**53562.22**
Services included in capitation:	42495.86
Services not included in capitation:	11066.36
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite-RCF/ID - FFS		15 Minutes	1	216.24	5.70	1232.57	
Respite-HHA Specialized - FFS		15 Minutes	1	591.48	16.72	9889.55	
Respite-Camp - FFS		15 Minutes	130	730.51	4.71	447291.27	
Respite-HHA Basic Individual - FFS		15 Minutes	1	877.68	7.72	6775.69	
Teen Day Camp - 13 to 21 Years Old - FFS		15 Minutes	4	800.30	5.67	18150.80	
Group Summer Day Camp - Group Recreational - FFS FFS		15 Minutes	7	728.44	5.67	28911.78	
Respite-Nursing Facility - FFS		15 Minutes	1	559.68	5.32	2977.50	
Respite-ICF/ID - FFS		15 Minutes	1	180.91	5.61	1014.91	
Respite Resident Camp-Weeklong - FFS		15 Minutes	170	138.10	7.18	168564.86	
Group Specialized Summer Day Camp - FFS		15 Minutes	41	145.64	16.57	98943.45	
Supported Employment Total:							17089156.64
Maintain Employment - Individual		15 Minutes	610	17.80	70.36	763968.88	
Maintain Employment - Small Group		15 Minutes	813	1083.37	3.00	2642339.43	
Long Term Job Coaching		Month	2648	4.20	1198.47	13328903.95	
Maintain Employment - Individual - FFS		15 Minutes	12	17.80	70.36	15028.90	
Maintain Employment - Small Group - FFS		15 Minutes	16	1083.37	3.00	52001.76	

GRAND TOTAL:	791649595.45
Total: Services included in capitation:	628088738.54
Total: Services not included in capitation:	163560856.91
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	53562.22
Services included in capitation:	42495.86
Services not included in capitation:	11066.36
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Long Term Job Coaching - FFS		Month	57	4.20	1198.47	286913.72	
Home Health Aide Services Total:							39027.50
Home Health Aide Services		Hour	2	518.50	25.09	26018.33	
Home Health Aide Services - FFS		Hour	1	518.50	25.09	13009.16	
Nursing Total:							888012.49
Nursing Care in the Home/LPN; Per Hour		Hour	20	486.14	48.07	467375.00	
Nursing Care in the Home/RN; Per Hour		Hour	6	486.14	48.07	140212.50	
Nursing Care in the Home/LPN; Per Hour - FFS		Hour	9	486.14	48.07	210318.75	
Nursing Care in the Home/RN; Per Hour - FFS		Hour	3	486.14	48.07	70106.25	
Financial Management Services Total:							16762552.59
Financial Management Services		Month	2052	94.43	74.90	14513399.96	
Financial Management Services - FFS		Month	318	94.43	74.90	2249152.63	
Independent Support Broker Total:							220556.47
Independent Support Broker		Month	2052	5.33	17.46	190962.81	
Independent Support Broker - FFS		Month	318	5.33	17.46	29593.65	
Individual Directed Goods and Services Total:							1009479.70
Individual Directed		Month				874030.52	

GRAND TOTAL:	791649595.45
Total: Services included in capitation:	628088738.54
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Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	53562.22
Services included in capitation:	42495.86
Services not included in capitation:	11066.36
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goods and Services			2052	70.52	6.04		
Individual Directed Goods and Services - FFS		Month	318	70.52	6.04	135449.17	
Self Directed Community Support and Employment Total:							669837.84
Self Directed Community Support and Employment		Month	2052	20.60	13.72	579960.86	
Self Directed Community Support and Employment - FFS		Month	318	20.60	13.72	89876.98	
Self Directed Personal Care Total:							3394396.48
Self Directed Personal Care		Month	2052	27.66	51.78	2938945.81	
Self Directed Personal Care - FFS		Month	318	27.66	51.78	455450.67	
Consumer Directed Attendant Care (CDAC) - skilled Total:							4441161.07
CDAC - Agency - 15 Minutes		15 Minutes	20	4884.29	15.55	1519014.19	
CDAC - Individual - 15 Minutes		15 Minutes	30	3250.18	10.35	1009180.89	
CDAC - Agency - 15 Minutes - FFS		15 Minutes	15	4884.29	15.55	1139260.64	
CDAC - Individual - 15 Minutes - FFS		15 Minutes	23	3250.18	10.35	773705.35	
Consumer Directed Attendant Care (CDAC) - unskilled Total:							6747723.52
CDAC- Agency - 15 Minutes		15 Minutes	192	695.89	6.21	829723.56	

GRAND TOTAL:	791649595.45
Total: Services included in capitation:	628088738.54
Total: Services not included in capitation:	163560856.91
Total Estimated Unduplicated Participants:	14780
Factor D (Divide total by number of participants):	53562.22
Services included in capitation:	42495.86
Services not included in capitation:	11066.36
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CDAC-Individual - 15 Minutes		15 Minutes	286	2554.29	4.13	3017076.26	
CDAC-Agency - 15 Minutes - FFS		15 Minutes	144	695.89	6.21	622292.67	
CDAC-Individual - 15 Minutes - FFS		15 Minutes	216	2554.29	4.13	2278631.02	
Enabling Technology for Remote Support Total:							2417250.87
1 Job (Equipment / Technology)		1 Job	636	8.00	451.09	2295145.92	
1 Job (Equipment / Technology) - FFS		1Job	33	8.00	451.09	119087.76	
1 Assessment		1 Assessment	636	1.00	4.51	2868.36	
1 Assessment - FFS		1 Assessment	33	1.00	4.51	148.83	
Home and Vehicle Modification Total:							105520.41
Home and Vehicle Modification		Occurrence	19	1.03	4097.88	80195.51	
Home and Vehicle Modification - FFS		Occurrence	6	1.03	4097.88	25324.90	
Interim Medical Monitoring and Treatment Total:							1013973.78
IMMT - Nurse		15 Minutes	1	1872.27	12.28	22991.48	
IMMT - Aide or CNA		15 Minutes	14	1255.98	9.90	174078.83	
IMMT - Nurse - FFS		15 Minutes	2	1872.27	12.28	45982.95	
IMMT - Aide or CNA - FFS		15 Minutes	62	1255.98	9.90	770920.52	
Medical Day Care for Children Total:							8990184.00
Medical Day Care for		15 Minutes				5993456.00	

GRAND TOTAL:	791649595.45
Total: Services included in capitation:	628088738.54
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Total Estimated Unduplicated Participants:	14780
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Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Children 15 Minutes			118	5600.00	9.07		
Medical Day Care for Children 15 Minutes - FFS		15 Minutes	59	5600.00	9.07	2996728.00	
Personal Emergency Response or Portable Locator System Total:							126383.35
Personal Emergency Response-Initial		Installation	112	1.38	57.15	8833.10	
Personal Emergency Response-Ongoing		Installation	468	14.48	11.38	77118.16	
Personal Emergency Response-Initial - FFS		Installation	53	1.38	57.15	4179.95	
Personal Emergency Response-Ongoing - FFS		Installation	220	14.48	11.38	36252.13	
Supported Community Living Total:							362944138.20
Supported Community Living, Per Day		Day	3720	1047.65	7.99	31139091.42	
Supported Community Living, 15 Minutes		15 Minutes	3288	326.03	186.78	200225664.62	
Supported Community Living, Per Day - FFS		Day	2115	1047.65	7.99	17704080.20	
Supported Community Living, 15 Minutes - FFS		15 Minutes	1870	326.03	186.78	113875301.96	
Transportation Total:							10538925.26
Per Mile		Mile	886	440.94	6.89	2691735.87	
Per Trip		Trip	1895	125.10	27.56	6533497.62	

GRAND TOTAL:	**791649595.45**
Total: Services included in capitation:	628088738.54
Total: Services not included in capitation:	163560856.91
Total Estimated Unduplicated Participants:	**14780**
Factor D (Divide total by number of participants):	**53562.22**
Services included in capitation:	42495.86
Services not included in capitation:	11066.36
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Per Mile - FFS		Mile	126	440.94	6.89	382797.65	
Per Trip - FFS		Trip	270	125.10	27.56	930894.12	
GRAND TOTAL:							**791649595.45**
Total: Services included in capitation:							628088738.54
Total: Services not included in capitation:							163560856.91
Total Estimated Unduplicated Participants:							**14780**
Factor D (Divide total by number of participants):							**53562.22**
Services included in capitation:							42495.86
Services not included in capitation:							11066.36
Average Length of Stay on the Waiver:							354