

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 section 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 waiver's 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 - Brain Injury (BI)

C. Waiver Number: IA.0299

Original Base Waiver Number: IA.0299.

D. Amendment Number:

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

01/01/26

Approved Effective Date of Waiver being Amended: 10/01/24

2. Purpose(s) of Amendment

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

The state is submitting a technical amendment to:

1. Updating the tool used for level of care determinations from Case Management Comprehensive Assessment to the interRAI-Early Years for 0-3 year olds
2. Add Core Standardized Assessment to contracted entities in Appendix A
3. Removed the individual Consumer Directed Attendant Care (CDAC) provider type, renamed the service to Attendant Care
4. Amend the questions and scoring of the WPNA (Waiver Priority Needs Assessment)
5. Align service definitions, scope, and limitations for alike services across waivers
6. Allow members to choose whether they work with an ISBs (Individual Support Brokers), making it optional rather than mandatory for members who self-direct their services.
7. Update the term Exception to Policy (ETP) to Waiver of Iowa Administrative Rules (WoAR)
8. SCL: correct incorrect IAC code reference and update 15 min. unit of service per year limitation
9. Reduce Point in Time count to reflect what is currently being funded through fiscal appropriations.
10. Increase Reserved Capacity slots for community based neurobehavioral rehabilitation services (CNRS) from 15 to 20 per year
11. Remove references to Integrated Health Home (IHH) and IHH Coordinators due to SPA sunseting 12/31/2025
12. Add the requirement that individuals with an intellectual disability or a developmental disability have face to face contact with the case manager at least every other month.

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	Main 2, 6, 7, 8, B
Appendix A - Waiver Administration and Operation	3
Appendix B - Participant Access and Eligibility	3, 6
Appendix C - Participant Services	1, 2
Appendix D - Participant Centered Service Planning and Delivery	1, 2
Appendix E - Participant Direction of Services	1, 2
Appendix F - Participant Rights	
Appendix G - Participant Safeguards	1, 2, 3
Appendix H	
Appendix I - Financial Accountability	1, 2, 3
Appendix J - Cost-Neutrality Demonstration	2

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:

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 section 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 - Brain Injury (BI)

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.0299

Draft ID: IA.012.06.02

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/24

Approved Effective Date of Waiver being Amended: 10/01/24

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: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 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 in 42 CFR § 440.160**Nursing Facility**

Select applicable level of care

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

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

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

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

1. Request Information (3 of 3)**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable**Applicable**

Check the applicable authority or authorities:

Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**Waiver(s) authorized under section 1915(b) of the Act.**

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

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

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

section 1915(b)(2) (central broker)

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

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

A program operated under section 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 section 1915(i) of the Act.

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

A program authorized under section 1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The goal of the Iowa HCBS Brain Injury (BI) 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 nursing facility (as defined in 42 CFR §440.40 and 42 CFR §440.155) or intermediate care facility for individuals with intellectual disabilities (ICF/IID) (as defined in 42 CFR §440.150) level of care. Iowa Medicaid's Medical Services Unit (MSU) is responsible for determining the initial level of care for all applicants. HHS's Core Standardized Assessment (CSA) vendor is responsible for conducting level of care reevaluations, with Iowa Medicaid having final review and approval authority for all reassessments that indicate a change in the level of care. MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. In the event there is a waiting list for waiver services at the time of initial assessment, 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 attendant care, case management, adult day care, positive behavioral supports, enabling technology for remote support, family training, home and vehicle modification, interim medical monitoring and treatment, medical day care for children, personal emergency response, positive behavioral supports, prevocational, respite, supported community living, supported employment, specialized medical equipment, transportation, financial management services, independent support brokerage services, self-directed personal care, and individual directed goods and services.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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

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

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 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 section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

Not Applicable

No

Yes

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

No

Yes

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

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

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

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

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

F. FFP Limitation. In accordance with 42 CFR Part 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. 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 Part 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 Health 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 Brain Injury Amendment:

- 1) Iowa Medicaid Website Posting - <https://hhs.iowa.gov/public-notice/XXXXXXX>
- 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 Brain Injury Waiver Public Notice and to provide a copy of the CMS Waiver Amendment 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 amendments. The public posting period was the same for this process. The public notice period began on August XX, 2025, and closed on September XX, 2025. There were XX public comments received during the notice period for the Brain Injury waiver.
- 4) Iowa Tribal Nations Notification - The Tribal Nations were notified of the intent to amend the waiver via email August XX, 2025. The comment period remained open through September XX, 2025. The Tribal liaison for the department received XX 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:

Moskowitz

First Name:

LeAnn

Title:

Brain Injury Waiver Program Manager

Agency:

Iowa Department of Health and Human Services/Iowa Medicaid Enterprise

Address:

321 E 12th St.

Address 2:**City:**

Des Moines

State:

Iowa

Zip:

50319

Phone:

(515) 321-8922

Ext:

TTY

Fax:

(515) 256-1306

E-mail:

leann.moskowitz@hhs.iowa.gov

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:

321 E 12th St.

Address 2:**City:**

Des Moines

State:

Iowa

Zip:

50319

Phone:

(515) 256-4636

Ext:

TTY

Fax:

E-mail:

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 section 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:

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:

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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”.

Supported Employment (SE) delivered via the telehealth modality additional information:

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

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

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

SCL Delivered Through Remote Support and Telehealth 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 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.

he following are requirements for providers delivering SCL through the Host Home Model:

The SCL provider agency is the administrative agency responsible for oversight of host homes providing SCL services. The provider agency is responsible for all the following:

- Implementing policies and procedures addressing the recruitment, screening, training, ongoing support, oversight, and retention of host home contractors.
- Assuring SCL services delivered in the Host Home are provided in compliance with the Iowa Administrative Rules, HCBS Waiver Provider Manual , HCBS Waiver Application(s)
- Recruitment of host home providers (independent contractors), screening, conduct background checks, and other assessments of host home providers and locations.
- o Complete child and dependent adult abuse background checks prior to contracting.
- o Complete criminal background checks on each adult residing in the Host Home prior to contracting.
- o Solicit an evaluation and follow recommendations for hire when a hit is found on a background check prior to contracting.
- o Screen potential contractors for exclusion from participation in Federal health care programs prior to hire.
- o Validate that the Host Home provider has a valid driver's license and liability insurance.
- o Ensure Host Home providers are minimally qualified by age, education, certification, experience, and training required or recommended and demonstrate competency for the services provided commensurate with the member(s) served.
- Completion of assessments with host homes and members to aid in the matching process between the host home and the member.
- Conduct assessments of host homes to ensure the home is safe and healthy including.
- o Working smoke detectors
- o Working carbon monoxide detectors
- o Free of vermin or pest infestation
- o Accessible to the member.
- o As a best practice home visits should occur a minimum of once per quarter.
- Contracting with the Host Home provider for the delivery of HCBS Waiver SCL in accordance with the member's Person-Centered Service Plan (PCSP) and applicable IAC Chapter 77, 78, and 79.
- o Ensure homeowner or renters insurance is in place to cover contents for individual(s) served if they choose to purchase a policy.
- o Ensure a lease or written residency agreement is in place.
- o Ensure home is maintained in accordance with health and safety guidelines. For Host Homes, the administering agency can terminate the agreement with the host home provider if the repairs or modifications are not completed to satisfaction.
- Assure the Host Homes have a signed copy of the current PCSP.
- Provide training or ensure training is completed by the host home providers and host back up support on the member's PCSP.
- Provide healthcare maintenance and medication management oversight to the host home provider as applicable.
- Provide the Host Home with access to 24 hour on-call support.
- Actively participate as a member of the member's HCBS PCSP IDT team.

- Monitor the ongoing implementation of the member's PCSP. Complete monthly reviews with progress on outcomes and goals of the individual.
- Monitor minor and major incidents and ensure timely reporting, investigation and follow-up in accordance with 441.77.25, 441.77.37 and 441.77.39
- Monitor service documentation to ensure the host is completing written documentation as required by the SCL provider agency and IAC 441.79.3
- Make payment to the host home provider in accordance with the contract for services.
- Ensure that there is a room and board agreement in place between the member and the host.
- Assist the host home in finding back-up relief providers as needed.
- Execute contracts between independent contractors and the SCL provider agency.
- Conduct quality oversight activities including the following:
 - o Maintain regular contact with the Host Home provider. i.e., home visits, phone calls, meeting, etc. and document those contact.
 - Document all quality assurance activities, including home visits, phone consultations and recommendations and have available upon request.
 - Complete monthly reviews with progress on outcomes and goals of the individual.
 - Make recommendations to the host home provider regarding appropriate service documentation, record keeping and individual services and supports.
 - Ensure the host home provider completes required training:
 - o The philosophy of HCBS, including HCBS settings requirements and expectations
 - o The organization's mission, policies, and procedures
 - o The organization's policy related to identifying and reporting abuse.
 - o 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)
 - o Members' rights including outcomes for rights and dignity as applicable.
 - o Restrictive interventions (restraints, rights restrictions, and behavior intervention)
 - o Individual members' support needs (prior to serving the member and as updates
 - o Specific behavior support or de-escalation curriculum such as Mandt, Safety-Care, PBIS, CPI, or other
 - o Confidentiality and safeguarding member information
 - o The organization's policy related to member's medication.
 - o An approved Medication Manager training for any contractors that are administering controlled substances
 - o Identifying and reporting incidents
 - o Service documentation
 - o The HHS designated Brain Injury Training (within 60 days of providing BI Waiver services)

SE delivered via Telehealth or SCL Delivered via Remote Support or Telehealth additional information:

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

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.

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

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

need is identified.

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 (BLTSS), 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.

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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.
- Developing service plans, coordinating care, and authorizing and initiating waiver services for all members.
- 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.

Core Standardized Assessment (CSA)- CSA contractor is responsible for conducting assessments to determine level of care evaluations and reevaluations for all applicants and members, using HHS designated tools.

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:

The Iowa Department of Health and Human Services, Iowa Medicaid policy staff, are responsible for oversight of the contacting entities. The HHS Iowa Medicaid is the state agency responsible for conducting the operational and administrative functions of the Brain Injury 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. The 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. Housed in a single building, the 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 present their performance on contract standards at a monthly meeting to the Medicaid Policy Staff. Monthly meetings are designed to facilitate communication among the various business units within the Iowa Medicaid to ensure coordination of operations and performance outcomes. Further, non-MCO contracted entities and Medicaid Policy staff are located at the same site, which limits the barriers of routine management and oversight. In addition, all contracted agencies are required to complete a comprehensive quarterly report on their performance to include programmatic and quality measures designed to measure the contract activities as well as trends identified within Medicaid programs and populations.

The State has established a MCO Oversight and Supports Bureau within 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 oversees contract compliance for one designated MCO. The MCO account managers serve as liaisons between the MCOs and the State and are the point of contact coordinating communications and connecting subject matter experts. The MCO Bureau works directly with the Iowa Medicaid LTSS Policy unit which oversees and manages the HCBS program policy and the 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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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 (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px;">MCO</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	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: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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 = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">MCOs</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify:	

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Data Aggregation and Analysis:

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

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

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 state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Sub-State Entity	Quarterly
Other Specify: Contracted Entity including 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 Administrative Authority that are currently non-operational.

No

Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	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	0		
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age			
				Maximum Age Limit		No Maximum Age Limit	
		Autism					
		Developmental Disability					
		Intellectual Disability					
Mental Illness							
		Mental Illness					
		Serious Emotional Disturbance					

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

“Brain injury” means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person’s physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

- Malignant neoplasms of brain, cerebrum.
- Malignant neoplasms of brain, frontal lobe.
- Malignant neoplasms of brain, temporal lobe.
- Malignant neoplasms of brain, parietal lobe.
- Malignant neoplasms of brain, occipital lobe.
- Malignant neoplasms of brain, ventricles.
- Malignant neoplasms of brain, cerebellum.
- Malignant neoplasms of brain, brain stem.
- Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
- Malignant neoplasms of brain, cerebral meninges.
- Malignant neoplasms of brain, cranial nerves.
- Secondary malignant neoplasm of brain.
- Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
- Benign neoplasm of brain and other parts of the nervous system, brain.
- Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
- Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
- Encephalitis, myelitis and encephalomyelitis.
- Intracranial and intraspinal abscess.
- Anoxic brain damage.
- Subarachnoid hemorrhage.
- Intracerebral hemorrhage.
- Other and unspecified intracranial hemorrhage.
- Occlusion and stenosis of precerebral arteries.
- Occlusion of cerebral arteries.
- Transient cerebral ischemia.
- Acute, but ill-defined, cerebrovascular disease.
- Other and ill-defined cerebrovascular diseases.
- Fracture of vault of skull.
- Fracture of base of skull.
- Other and unqualified skull fractures.
- Multiple fractures involving skull or face with other bones.
- Concussion.
- Cerebral laceration and contusion.
- Cerebral edema.
- Cerebral palsy.
- Subarachnoid, subdural, and extradural hemorrhage following injury.
- Other and unspecified intracranial hemorrhage following injury.
- Intracranial injury of other and unspecified nature.
- Poisoning by drugs, medicinal and biological substances.
- Toxic effects of substances.
- Effects of external causes.
- Drowning and nonfatal submersion.
- Asphyxiation and strangulation.
- Child maltreatment syndrome.
- Adult maltreatment syndrome.
- Status epilepticus.

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	1747
Year 2	1747
Year 3	1747
Year 4	1747
Year 5	1747

- 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	1704
Year 2	1438
Year 3	1438
Year 4	1438
Year 5	1438

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
Nursing Facility (NF), Skilled Nursing Facility (SNF) and Intermediate Care Facility for Persons with Intellectual Disabilities(ICF/ID)
Community-Based Neurobehavioral Rehabilitation Services (CNRS)

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):

Nursing Facility (NF), Skilled Nursing Facility (SNF) and Intermediate Care Facility for Persons with Intellectual Disabilities(ICF/ID)

Purpose (describe):

The state will reserve thirty slots each waiver year for use by individuals living in a Nursing Facility (NF) or in Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) or other out of state (OOS) facility serving individuals with brain injury.

Slots are available for use by any eligible person for the BI waiver residing in a Nursing Facility, Skilled Nursing Facility or Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) and has been residing there at least four months, and is choosing the BI waiver program over institutional services. Slots will be allocated based on the date of application for the reserved slot.

Once on the BI waiver program, the individual is transitioned to funding under the BI waiver through the county of legal settlement or through State case status.

Describe how the amount of reserved capacity was determined:

The thirty slots are based on the anticipated movement of individuals moving from out-of-State nursing facilities (NF) or skilled nursing facilities (SNF) and Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) and movement within the State to community based settings funded through the BI waiver.

The reserved capacity slots are intended to ensure that individuals living in an NF or ICF/ID for four or more months have a slot available to them to make the transition into the community and continued funding through the BI waiver.

The MFP grant provides more opportunities for participants living in and NF or ICF/ID to move to community based services funded through the BI waiver. The MFP grant funds the first 365 days of services provided in the community. After the first year, the individual will apply for and receive funding through the BI waiver. The State has provided access through reserved capacity prior to MFP.

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

Waiver Year	Capacity Reserved
Year 1	30
Year 2	30
Year 3	30
Year 4	30
Year 5	30

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):

Community-Based Neurobehavioral Rehabilitation Services (CNRS)

Purpose (describe):

The state will set aside slots each year for individuals who are receiving residential community based neurobehavioral rehabilitation services (CNRS) to enable them to transition to home with the support of the services available through the BI Waiver once their treatment with the CNRS provider is completed.

The CNRS program is designed to provide intensive neurobehavioral rehabilitation services to individuals diagnosed with a brain injury co-occurring with a serious mental illness and are at risk of institutionalization, incarceration or homelessness due to effects of their brain injury and mental illness.

Describe how the amount of reserved capacity was determined:

The slots are based on the anticipated movement of CNRS who would access Community Based Neurobehavioral services as an alternative to jail, homelessness or out of state institutionalization and are not otherwise eligible for a reserved capacity slot under the ICF/ID, SNF, or NF criteria. These reserved capacity slots are intended to ensure that CNRS who have been diverted from jail or institutionalization and are receiving residential community-based neurobehavioral rehabilitation services for six or more months have a funding slot available to them to make the transition to home with the continued funding of support services through the BI waiver.

Individuals accessing these slots do not have access to the Money Follows the Person Grant program as they are not residing in a medical institution.

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

Waiver Year	Capacity Reserved
Year 1	15
Year 2	20
Year 3	20
Year 4	20
Year 5	20

Appendix B: Participant Access and Eligibility

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

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

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

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

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

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

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

--

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

Per Iowa Code 441-83.82(4), “if no waiver slot is available, the department shall enter the applicant on a waiting list according to the following: (1) applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services; (2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.”

HHS assess applicants that submit the Waiver Priority Needs Assessment (WPNA) to determine if the applicant has a priority need based on risk of institutionalization, emergent or urgent need.

Applicants will receive numeric risk scores based on their responses to the risk of institutionalization, emergent needs, and urgent needs questions. Scoring methodology is presented with the questions below. If applicants receive equal risk scores, 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.

Risk of Institutionalization: A person is considered at “risk of institutionalization” if they report certain risk indicators associated with higher rates of institutionalization.

Risk of institutionalization criteria is as follows:

1. The individual is aged 55 or older.
 - a. Age 55-64 -Score: 1
 - b. Age 65 or above- Score : 2

2. The individual has stayed overnight at a hospital in the last 3 months for a reason other than giving birth.

For Adults:

- a. 1 inpatient stay- Score :3
- b. 2 inpatient stays- Score: 5
- c. 3-4 inpatient stays- Score: 7
- d. 5+ inpatient stays- Score: 9

For Children:

- a. 1 inpatient stay- Score :2
- b. 2-3 inpatient stays- Score: 4
- c. 4+ inpatient stays – Score: 6

3. The individual has visited an emergency department (not urgent care) at least twice in the last 3 months.

For Adults:

2 or more visits- Score :2

For Children:

2 or more visits- Score :1

4.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.

Emergency need criteria are as follows(Check all that apply) Each Scores 2

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.
2. The individual has lost or will be losing housing within 30 days and has no other housing options available.
3. The individual 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 individual, and the individual must move from the home.
5. The individual cannot meet basic health and safety needs without immediate supports. (Not applicable to children under age 18 due to parental responsibility)
6. The individual is in danger or will experience abuse or neglect if the individual does not receive immediate support or services
7. The individual is in crisis and admission to a facility will be expected without supports in the next 30-60 days.
8. The caregiver is in extreme stress or pressure and will not be able to provide for the individual's health and safety if supports are not provided in the next 30 to 60 days.

5. 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.

Urgent need criteria are as follows:

1. The caregiver will need support within 60 days for the individual to remain living in their home.
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 individual is living in temporary housing and plans to move within 31 to 120 days. (Not applicable to CMH, PD and HD)
5. The individual is losing permanent housing and plans to move within 31 to 120 days. (Not applicable to CMH, PD and HD)
6. The caregiver is 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 individual.
8. The individual has behaviors that put the applicant at risk.
9. The individual has behaviors that put others at risk.
10. The individual is at risk of facility placement when needs could be met through community-based services.

Applicants who do not meet risk of institutionalization, emergent need, or urgent need criteria shall remain on the waiting list 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 complete and submit a WPNA for consideration at that time. 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.

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*):

Section 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)

Parents and Other Caretaker Relatives (42 CFR § 435.110)

Pregnant Women (42 CFR § 435.116)

Infants and Children under Age 19 (42 CFR § 435.118)

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 section 1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 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

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, 2027 (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 section 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 section 1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

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

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

The following formula is used to determine the needs allowance: 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.

The state has develop a method to carve out/identify the cost of home and community-based waiver services from the cost of other Medicaid services so that the individual's patient liability is applied only to the cost of home and community-based waiver services.

For Fee for service members, the patient liability is carried in the HCBS IoWANS system. A case manager is required to identify those HCBS services and provider combinations where patient liability will be applied and how much of the liability amount will be designated to that service. The authorized payment amount is reduced by the amount of the liability. This information is communicated to the MMIS Prior Authorization file. At the time of HCBS claim payment MMIS looks to the PA file for any HCBS service authorization limitation, including the maximum payable amount for a specific service.

One of the contracted Managed Care Organizations uses a similar process as explained above, except that the MCO's claim payment system carries the HCBS prior authorization and HCBS patient liability amounts. When the claim is submitted, the claims system identifies the authorization related to the claims and then applies HCBS patient liability amounts as authorized. This process omits any 'medical' or behavioral health claim not subject to HCBS patient liability withholding.

The other MCO utilizes edits/triggers within their claims adjudication system that are programmed to systemically only identify very specific claims perimeters that are subject to HCBS patient liability. Specific to HCBS, this is drilled down by specific procedure codes and modifier combinations that correspond to the member's eligibility enrollment type. The MCO processes HCBS patient liability on a 'first in, first out basis'. This means, if multiple providers/claims are submitted within the month, the first claim with HCBS service perimeters is subject to the patient liability withholding. If this first claim does not satisfy the full amount, the next claim received/processed would additionally be subject to patient liability withholding until the full dollar amount is satisfied for this month. This process omits any 'medical' or behavioral health claim not subject to HCBS patient liability withholding.

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 section 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 period after September 30, 2027 (or other date as required by law).

- c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).**

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 period after September 30, 2027 (or other date as required by law).

- d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)**

The state uses the post-eligibility rules of section 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 section 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:

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 or 42 CFR § 435.735:**

- 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 period beginning January 1, 2014 and extending through September 30, 2027 (or

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other date as required by law).

- e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).**

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).**

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).**

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

The provision of waiver services at least monthly

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

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

quarterly), specify the frequency:

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

As part of HCBS waiver enrollment, case management is required for each participant, regardless of delivery system. Following the first three months, the Case Managers must complete at least one contact per month with the individual or their authorized representative 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. This contact may be face-to-face, virtual, or via telehealth. Written communication does not constitute contact unless there are extenuating circumstances outlined in the enrollee's individualized service plan (ISP).

- If the individual has been diagnosed with an Intellectual and/or Developmental Disability, Case Managers must complete at least one, in-home, face-to-face contact every other month
- For those who are not diagnosed with Intellectual and/or Developmental Disability, the Case Manager must complete at least one, in-home, face-to-face contact every three months.

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 an entity under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

The Iowa Medicaid QIO Medical Services Unit is responsible for making all initial level of care decisions. Iowa Medicaid's CSA contractor performs the assessments for both initial and ongoing reviews. LOC decisions also include input from the case manager, community-based case manager, medical professional, and other appropriate professionals. The Iowa Medicaid QIO Medical Services Unit reviews and approves all reevaluations that indicate a change in the member's level of care. MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services.

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

Medical professionals (i.e., licensed physician, physician assistant or advanced registered nurse practitioner) perform the initial 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.

Iowa Medicaid QIO Medical Services uses the following assessments to evaluate and reevaluate applicants and members:

Brain Injury Waiver

Ages 0 – 3 interRAI- Early Years (EY) Assessment (0-47 months)

Ages 4 -20 interRAI – Pediatric Home Care (PEDS-HC) and Mayo Portland Adaptability Inventory (MPAI)

Ages 21-64 interRAI – Home Care (HC)and MPAI

interRAI- Early Years

The interRAI Early Years Assessment System (EY) is a tool intended for use with young children with developmental and mental health concerns and includes identification of family support needs. The assessment tool enables comprehensive care planning in community-based settings and is compatible with other interRAI assessments for children. The interRAI EY system comes equipped with scales, care-planning protocols, algorithms, and quality indicators and provides an extensive understanding of a child's strengths, needs and preferences across medical, social, developmental, and behavioral domains.

interRAI – Home Care Assessments

The interRAI Home Care Assessment System (HC) has been designed to be a user-friendly, reliable, person-centered assessment system that informs and guides comprehensive care and service planning in community-based settings around the world. It 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 HC can be used to assess persons with chronic needs for care as well as those with post-acute care needs (for example, after hospitalization or in a hospital-at-home situation). Areas of review include: (1) cognitive; (2) mood and behavior patterns; (3) physical functioning – mobility; (4) skin condition; (5) pulmonary status; (6) continence; (7) dressing and personal hygiene – ADLS; (8) physical functioning – eating; (9) medications; (10) communication/hearing/vision patterns; and (11) prior living - psychosocial.

In addition to the interRAI-HC, the most current version of the Mayo Portland Adaptability Inventory is completed and used to supplement the interRAI-HC tool for determining level of care for the Brian Injury Waiver.

Mayo Portland Adaptability Inventory (MPAI)

The Mayo-Portland Adaptability Inventory (MPAI) was primarily designed to assist in the clinical evaluation of people during the post acute (posthospital) period following acquired brain injury (ABI), and to assist in the evaluation of rehabilitation programs designed to serve these people.

Evaluation and rating of each of the areas designated by MPAI-4 items assures that the most frequent sequelae of ABI are considered for rehabilitation planning or other clinical interventions. MPAI-4 items represent the range of physical, cognitive, emotional, behavioral, and social problems that people may encounter after ABI. MPAI-4 items also provide an assessment of major obstacles to community integration which may result directly from ABI as well as features of the social and physical environment

- 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 interRAI HC Assessment Form is a Minimum Data Set screening tool that enables a trained assessor to assess multiple key domains of function, health, social support and service use. Particular interRAI HC items also identify persons who could benefit from further evaluation of specific problems or risks for functional decline. These are triggers that link the interRAI HC to a Clinical Assessment Protocol. The CAPS contain general guidelines for further assessment.

The HC system supports a variety of research-informed decision support tools that assist the assessor in planning and monitoring care. These include:

- *Scales for ADLs, cognition, communication, pain, depression, and medical instability
- *Clinical Assessment Protocols that contain strategies to address problem conditions as triggered by one or more HC item responses
- *Screening systems to identify appropriate outreach and care pathways for prospective clients (the MI Choice and MAPLe systems)
- *A quality monitoring system (Home Care Quality Indicators, or HCQIs)
- *A case-mix system that creates distinct service-use intensity categories (RUG-III/HC)

Iowa Medicaid QIO Medical Services may request additional information from the service worker, 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.

The interRAI Early Years (EY) Assessment Form is utilized for children age 0-3. The EY system supports research-informed decision support tools to support comprehensive care planning.

The interRAI Pediatric Home Care Assessment (PEDS-HC) is a standardized assessment tool developed for use in programs serving children with special health care challenges. The PEDS-HC instrument is designed to be used to assess the home care challenges of children and youths ranging in age from 4 through 20 who are seeking or receiving long-term services or supports.

The Mayo-Portland Adaptability Inventory (MPAI) was primarily designed to assist in the clinical evaluation of people during the postacute (posthospital) period following acquired brain injury (ABI), and to assist in the evaluation of rehabilitation programs designed to serve these people.

Evaluation and rating of each of the areas designated by MPAI-4 items assures that the most frequent sequelae of ABI are considered for rehabilitation planning or other clinical interventions. MPAI-4 items represent the range of physical, cognitive, emotional, behavioral, and social problems that people may encounter after ABI. MPAI-4 items also provide an assessment of major obstacles to community integration which may result directly from ABI as well as features of the social and physical environment

- 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. The initial assessment is completed by the Core Standardized Assessment (CSA) contractor Telligen and sent to the case manager who uploads the assessment 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 and when the case manager becomes aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. The CSR process uses the same assessment tool as is used with the initial level of care determination. It is the responsibility of the case manager to assure the assessment is initiated as required to complete the CSR. For fee-for-service members, the IoWANS system sends out a milestone 60 days prior to the CSR date to remind case managers of the upcoming annual LOC process. The CSA contractor completes these assessments, and the Iowa Medicaid QIO MSU conduct LOC redeterminations.

The CSA contractor is 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 CSA submits the level of care or functional eligibility information to the Iowa Medicaid QIO MSU. The State retains authority for determining Medicaid categorical, financial, level of care or needs-based eligibility and enrolling members 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. CSA is 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 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) needs assessments and reassessments; (v) service delivery against authorized services and providers; (vi) actions taken by the community-based case manager or care coordinator to address service gaps; and (vii) case notes.

MCOs are required to employ the same professionals. 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.

- 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*):

The CSA contactor is responsible for submitting LOC reevaluations of members within twelve (12) months of the previous evaluation. Reevaluations are tracked in the HHS Institutional and Waiver Authorization and Narrative System (IoWANS). An IoWANS milestone is sent out to the CSA contractor 60 days before the reevaluation is due.

One hundred percent (100%) of member LOC reevaluations must be completed within twelve (12) months of the previous evaluation. On a weekly basis, an IoWANS CSR report is extracted to identify overdue reevaluations and sent to the management team for HHS CSA management for resolution. The HHS CSA management submits a monthly 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 Iowa Medicaid.

Should 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, and contract termination. In the event of non-compliance with reevaluation timelines, the CSA contractor 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:

All evaluation and reevaluation level of care documents are faxed to the Iowa Medicaid QIO MSU regardless of delivery system (i.e., FFS members and MCO members) and placed in "OnBase." OnBase is the system that stores documents electronically and establishes workflow. In addition, the waiver member's case manager or community-based case manager is responsible for service coordination for each member. 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 member 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 state's quality improvement strategy, provide information in the following fields to detail the state's 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 QIO 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 = <div></div>
Other Specify:	Annually	Stratified Describe Group:

contracted entity		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Iowa Medicaid MQIDS 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 = <div>95% confidence level +/-5% margin of error</div>
Other Specify: <div>Contractor entity</div>	Annually	Stratified Describe Group:

		IA.0213 AIDS/HIV (.05%) IA.0242 ID (47%) IA.0299 BI (6%) IA.0345 PD Waiver (4%) IA.0819 CMH Waiver (4%) IA.4111 HD Waiver (9%) IA.4155 Elderly Waiver (30%)
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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

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 state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

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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) 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 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 determine that there is documentation that HCBS provider choice was offered.

Iowa Medicaid's contractor for QIO 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.

Freedom of Choice for fee-for-service (FFS) participants 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 participants 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 is 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 beneficiaries may call the 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	Case Management		
Statutory Service	Prevocational Services		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Extended State Plan Service	Specialized Medical Equipment		
Supports for Participant Direction	Financial Management Service		
Supports for Participant Direction	Independent Support Broker		
Supports for Participant Direction	Individual Directed Goods and Services		
Other Service	Attendant Care		
Other Service	Enabling Technology for Remote Support		
Other Service	Family Training Services		
Other Service	Home and Vehicle Modification		
Other Service	Interim Medical Monitoring and Treatment (IMMT)		
Other Service	Medical Day Care for Children		
Other Service	Personal Emergency Response System or Portable Locator System		
Other Service	Positive Behavioral Support and Consultation		
Other Service	Skilled Attendant Care		
Other Service	Supported Community Living		
Other Service	Transportation		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

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

Service Definition (Scope):

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

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

Transportation is not a required element of Adult Day Care but if the cost of transportation is provided and charged to Medicaid, the cost of transportation must be included in the Adult Day Care per diem. If transportation to and from Adult Day Care is needed (based on the Adult Day Care provider's transportation), the case manager will authorize and monitor the authorized transportation as needed.

Adult Day Care does not cover therapies: occupational therapy, physical therapy, or speech therapy. The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager.

Adult day care services occur in nonresidential settings that have been assessed to meet the HCBS settings requirements and adult day care in the home occurs in the member's own home.

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

A unit of service is 15 minutes (up to 4 units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day) or an extended day (8.25 to 12 hours per day). Adult day services have an upper limit if there is no Veterans Administration contract. The upper limits are published in the Iowa Administrative Code and are subject to change on a yearly basis.

*When Adult Day Care services are provided to a person 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 limit for Specialized Respite at the time the service is delivered, whichever applies.

The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services are appropriately authorized in the person's person-centered service plan as needed. Where there is a potential for overlap, services must first be exhausted under Section 110 of the Rehabilitation Act of 1973. The first line of prevention of duplicative billing for similar types of services, such as family and community support service, is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as described in the person-centered service plan.

Adult day care and respite are separate and distinct services. Adult Day care can be provided while the primary care giver(s) are working whereas respite is intended to give the primary care giver a break from care and may not be provided while the primary care giver(s) is working. Adult day care service cannot be authorized to be provided at the same time.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	HCBS Provider Agency certified for Specialized Respite Care
Agency	Adult Day Care Provider
Agency	Home Health Agency certified to provide Specialized Respite
Agency	Home Care Agency certified to provide Specialized Respite
Agency	Supported Community Living providers certified under the BI or ID Waivers to provide Specialized Respite

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Adult Day Care****Provider Category:**

Agency

Provider Type:

HCBS Provider Agency certified for Specialized Respite Care

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

Certified to provide Respite by the Department's Home and Community Based Services Quality Oversight Unit as outlined in Iowa Administrative Code 441 Chapter 77 and the HCBS Waiver Provider Manual.

Other Standard (specify):

Providers must be:

- (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 person or a parent or stepparent of a person aged 17 or under.
- (4) Not the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based service.

The adult day care 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 Provider

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

Meeting the requirements of Iowa administrative Code 441.77, 441.78, HCBS Waiver Provider Manual and certified by the Iowa Department of Inspections and Appeals as being in compliance with the standards for adult day services under Iowa Administrative Code 481.70.

Other Standard (specify):

Providers must be:

- (1) At least 18 years of age.
- (2) Qualified by training
- (3) Not the spouse or guardian of the member
- (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based service.

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

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

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

Frequency of Verification:

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 Specialized Respite

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

Home health agencies certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891), and, unless exempted under Iowa Administrative Code, have submitted a surety bond.

Other Standard (specify):

Providers must be:

- (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 person or a parent or stepparent of a person aged 17 or under.
- (4) Not the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based service.

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

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

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Home Care Agency certified to provide Specialized 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. The Home Care provider must be: a. Certified as a home health agency under Medicare, or b. Authorized to provide similar services through a contract with HHS for local public health services. The agency must provide a current local public health services contract number.

Other Standard (specify):

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

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

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

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License (specify):

Certificate (specify):

Providers certified by the Department's Home and Community Based Services Quality Improvement Organization to provide Supported Community Living in accordance with Iowa Administrative Code 441 Chapter 77

Other Standard (specify):

Providers must be:

- (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 person or a parent or stepparent of a person aged 17 or under.
- (4) Not the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based service.

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

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

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:**

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

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

Service Definition (Scope):

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

Case Management includes:

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

Providers delivering this service via the Telehealth service delivery option must demonstrate policies and procedures that include:

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

“Telehealth” means the delivery of services through the use of real-time interactive audio and video, or other real-time interactive electronic media, regardless of where the health care professional and the covered person are each located.

“Telehealth” does not include the delivery of health care services delivered solely through an audio-only telephone, electronic mail message, or facsimile transmission.

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

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

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

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

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

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

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

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

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

Payment for FFS case management may not be made until the member is enrolled in the waiver. Payment can also only be

made if case management activity is performed on behalf of the member during the month. Case Managers are required to have at least quarterly face to face contacts and monthly collateral contacts.

Providers delivering this service via the Telehealth service delivery option must demonstrate policies and procedures that include:

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

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

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency - HHS
Agency	Agency - Provider Chapter 24 accredited
Agency	Agency- County

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

Provider Type:

Agency - HHS

Provider Qualifications

License (*specify*):

Certificate (*specify*):

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

Other Standard (*specify*):

Qualified case managers and supervisors” means people who have the following qualifications:

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

) Case management services. "Case management services" means those services established pursuant to Iowa Code section 225C.20.

a. Performance benchmark. Case management services link individuals using the service to service agencies and support systems responsible for providing the necessary direct service activities and coordinate and monitor those services.

b. Performance indicators.

(1) Staff clearly define the need for case management and document it annually.

(2) At a minimum, the team is composed of the individual using the service, the case manager, and providers or natural supports relevant to the individual's service needs. The team may also include family members, at the discretion of the individual using the service.

(3) The team works with the individual using the service to establish the service plan that guides and coordinates the delivery of the services.

(4) The case manager advocates for the individual using the service.

(5) The case manager coordinates and monitors the services provided to the individual using the service.

(6) Documentation of contacts includes the date, the name of the individual using the service, the name of the case manager, and the place of service.

(7) The case manager holds individual face-to-face meetings at least quarterly with the individual using the service.

(8) Case managers do not provide direct services. Individuals using the service are linked to appropriate resources, which provide necessary direct services and natural supports.

(9) Individuals using the service participate in developing an individualized crisis intervention plan that includes natural supports and self-help methods.

(10) Documentation shows that individuals using the service are informed about their choice of providers as provided in the county management plan.

(11) Within an accredited case management program, the average caseload is no more than 45 individuals per each full-time case manager. The average caseload of children with serious emotional disturbance is no more than 15 children per full-time case manager.

(12) The case manager communicates with the team and then documents in the individual's file a quarterly review of the individual's progress toward achieving the goals

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

Provider Type:

Agency - Provider Chapter 24 accredited

Provider Qualifications

License (specify):

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

Certificate (*specify*):

--

Other Standard (*specify*):

“Qualified case managers and supervisors” means people who have the following qualifications:

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

) Case management services. “Case management services” means those services established pursuant to Iowa Code section 225C.20.

a. Performance benchmark. Case management services link individuals using the service to service agencies and support systems responsible for providing the necessary direct service activities and coordinate and monitor those services.

b. Performance indicators.

(1) Staff clearly define the need for case management and document it annually.

(2) At a minimum, the team is composed of the individual using the service, the case manager, and providers or natural supports relevant to the individual’s service needs. The team may also include family members, at the discretion of the individual using the service.

(3) The team works with the individual using the service to establish the service plan that guides and coordinates the delivery of the services.

(4) The case manager advocates for the individual using the service.

(5) The case manager coordinates and monitors the services provided to the individual using the service.

(6) Documentation of contacts includes the date, the name of the individual using the service, the name of the case manager, and the place of service.

(7) The case manager holds individual face-to-face meetings at least quarterly with the individual using the service.

(8) Case managers do not provide direct services. Individuals using the service are linked to appropriate resources, which provide necessary direct services and natural supports.

(9) Individuals using the service participate in developing an individualized crisis intervention plan that includes natural supports and self-help methods.

(10) Documentation shows that individuals using the service are informed about their choice of providers as provided in the county management plan.

(11) Within an accredited case management program, the average caseload is no more than 45 individuals per each full-time case manager. The average caseload of children with serious emotional disturbance is no more than 15 children per full-time case manager.

(12) The case manager communicates with the team and then documents in the individual’s file a quarterly review of the individual’s progress toward achieving the goals

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

Provider Type:

Agency- County

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

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

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

Other Standard (specify):

Qualified case managers and supervisors” means people who have the following qualifications:

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

) Case management services. “Case management services” means those services established pursuant to Iowa Code section 225C.20.

a. Performance benchmark. Case management services link individuals using the service to service agencies and support systems responsible for providing the necessary direct service activities and coordinate and monitor those services.

b. Performance indicators.

(1) Staff clearly define the need for case management and document it annually.

(2) At a minimum, the team is composed of the individual using the service, the case manager, and providers or natural supports relevant to the individual’s service needs. The team may also include family members, at the discretion of the individual using the service.

(3) The team works with the individual using the service to establish the service plan that guides and coordinates the delivery of the services.

(4) The case manager advocates for the individual using the service.

(5) The case manager coordinates and monitors the services provided to the individual using the service.

(6) Documentation of contacts includes the date, the name of the individual using the service, the name of the case manager, and the place of service.

(7) The case manager holds individual face-to-face meetings at least quarterly with the individual using the service.

(8) Case managers do not provide direct services. Individuals using the service are linked to appropriate resources, which provide necessary direct services and natural supports.

(9) Individuals using the service participate in developing an individualized crisis intervention plan that includes natural supports and self-help methods.

(10) Documentation shows that individuals using the service are informed about their choice of providers as provided in the county management plan.

(11) Within an accredited case management program, the average caseload is no more than 45 individuals per each full-time case manager. The average caseload of children with serious emotional disturbance is no more than 15 children per full-time case manager.

(12) The case manager communicates with the team and then documents in the individual’s file a quarterly review of the individual’s progress toward achieving the goals

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

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Prevocational Services are services that provide career exploration, learning and work experiences, including volunteer opportunities, where the person can develop non-job-task-specific strengths and skills that lead to paid employment in person 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 person 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 person employment in the community. Participation in Prevocational Services is not a prerequisite for person or small group Supported Employment services.

Career exploration. Career exploration activities are designed to develop an individualized career plan and facilitate the

person's experientially based informed choice regarding the goal of person employment. Career exploration is completed in the person's local community or nearby communities and may include but is not limited to the following activities:

- 1) meeting with the person, and their family, guardian or legal representative to introduce them to Supported Employment and explore the person's employment goals and experiences
- 2) business tours,
- 3) informational interviews,
- 4) job shadows,
- 5) benefits education and financial literacy,
- 6) assistive technology assessment, and
- 7) other job exploration events.

Expected outcome of service.

- 1) The expected outcome of Prevocational Services is individualized employment in the general workforce, or self-employment, in a setting typically found in the community, where the person interacts with persons without disabilities, other than those providing services to the person or other persons with disabilities, to the same extent that persons without disabilities in comparable positions interact with other persons; and for which the person 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 persons 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 person.

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

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

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager

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

A unit of service is one hour.

Career exploration may be authorized for up to 34 hours, to be completed over 90 days.

A person's 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).

Excluded services and costs. Services, activities, costs, and time that are not covered and for which payment shall not be made include the following:

- (1) Services that are available to the person 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 person for the service under these programs shall be maintained in the service plan of each person receiving Prevocational Services.
- (2) Services available to the person 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 persons for participating in Prevocational Services.
- (4) Support for persons 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 persons volunteering to benefit the service provider is prohibited.
- (5) The provision of vocational services delivered in facility-based settings where persons 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 person in continuing Prevocational Services or any employment situation similar to sheltered employment.

Limitations.

- 1) Time limitation for persons starting Prevocational Services. Participation in this service 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 person 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 person, as identified in the person's current service plan; or
2. The person 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 person wants, as identified in the person's current service plan, but the person 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 person is working in either individual or small group community employment; or
 3. The person 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 person's service plan; or
 4. The person 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 person 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 person is participating in career exploration activities.

The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services are appropriately authorized in the person's person-centered service plan as needed. Where there is a potential for overlap, services must first be exhausted under Section 110 of the Rehabilitation Act of 1973. The first line of prevention of duplicative billing for similar types of services, such as family and community support service, is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as described in the person-centered service plan.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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, but consistent with waiver objectives of avoiding institutionalization.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Prevocational Service Provider Accredited by CQL, International Center for Clubhouse Development, or CARF

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:

Prevocational Service Provider Accredited by CQL, International Center for Clubhouse Development, or CARF

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers accredited by the CQL, International Center for Clubhouse Development, or CARF as an organizational employment service provider or a community employment service provider in accordance with Iowa Administrative Code 441.77.

Providers responsible for the payroll of persons receiving supports 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) 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 person receiving supports. The immediate family member is defined as a parent, stepparent, sibling, or step sibling of the person.
- (3) A person providing direct support shall, within 6 months of hire, complete at least 9.5 hours of employment services training.
- (4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: 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:**

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Respite care services are services provided to the person that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of Respite is to enable the person to remain in their current living situation. Staff to person ratios shall be appropriate to the person's needs as determined by the person's interdisciplinary team.

"Usual caregiver" means an unpaid person or persons who reside with the member and are available on a 24-hour- per-day basis to assume responsibility for the care of the member. Usual and primary caregiver are used interchangeably. It means an unpaid person or persons who reside with the member and are available on a 24-hour- per-day basis to assume responsibility for the care of the member. If the person lives in the home and is a paid caregiver, then they do not meet the definition of usual or primary caregiver.

The interdisciplinary team shall determine if the person shall receive Basic Individual Respite, Specialized Respite or Group Respite, and shall approve the setting in which respite is provided. The state of Iowa allows respite services to be provided in a variety of community-based settings and by different provider types. Respite may be provided in the home, in a camp setting, in a community-based setting commensurate with how the setting is used by general public, and licensed facilities when the participant requires specialized Respite care.

All Respite services identified in Appendix J fall within the definition of Basic, Specialized or Group Respite.

- Basic Individual Respite means Respite provided on a staff-to-person ratio of one to one to persons without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.
- Group Respite means Respite provided on a staff to person ratio of less than one to one.
- Specialized Respite means Respite provided on a staff to person ratio of one to one to persons with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

When transportation is provided as a component of the Respite service the cost of transportation is included with the Respite reimbursement rate.

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager.

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

A unit of service is a 15-minute unit.

A maximum of 14 consecutive days of 24-hour respite care may be reimbursed. 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.

Services provided outside the person'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 (Intermediate Care Facilities for persons with Intellectual Disabilities (ICF/ID), residential care facilities for persons with

Intellectual Disabilities (RCF/ID), etc.). 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 person is out of the facility for hospitalization, home visits, vacations, etc. Waiver funds cannot be used to pay for a person to stay in the facility in a bed that is paid for as a reserved bed day.

Respite services are not to be provided to people during the hours in which the usual caregiver is employed except when the person is attending a 24-hour residential camp.

When the person elects to use Consumer Choice Option (CCO), the amount, frequency, or duration of the self-directed respite service is the same as respite that is not self-directed.

Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care provided outside of the person's home. This may include ICF/ID, RCF/ID, licensed foster care homes, Camps accredited by the American Camping Association, and hotels and motels. Hotels and motels are used based on individual need. Federal financial participation is included within the rate paid to the respite provider.

Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS waiver Supported Community Living services, Medicaid or HCBS waiver nursing, or Medicaid or HCBS Home Health Aide services. In addition, where there is a potential for overlap, services must first be exhausted under Section 110 of the Rehabilitation Act of 1973.

The first line of prevention of duplicative billing for similar types of services is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as ordered.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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

Remote/via Telehealth

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 Facility, ICF/ID, Hospital
Agency	Camp
Agency	Facility - Residential Care Facility
Agency	Assisted Living Program
Agency	HCBS Certified Respite Provider
Agency	Foster Care Facility
Agency	Home Care Agency
Agency	Child Care Facility
Agency	Adult Day Care Provider
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Facility, ICF/ID, Hospital

Provider Qualifications

License (specify):

Nursing facilities, intermediate care facilities for the people with intellectual disabilities, and hospitals enrolled as providers in the Iowa Medicaid program. 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.

Licensed by the Department of Inspections and Appeals under Iowa Administrative Code 481.

- Nursing facilities defined in Iowa Administrative Code 441: "Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.
- Hospitals enrolled as providers in the Iowa Medicaid program as defined in Iowa Administrative Code 441. All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program.
- Intermediate care facilities for people with intellectual disabilities licensed by the Department of Inspection and Appeal under Iowa Administrative Code 441. Iowa Code 135C defines intermediate care facility for persons with an intellectual disability as "an institution or distinct part of an institution with a primary purpose to provide health or rehabilitative services to three or more individuals, who primarily have an intellectual disability or a related condition and who are not related to the administrator or owner within the third degree of consanguinity, and which meets the requirements of this chapter and federal standards for intermediate care facilities for persons with an intellectual disability established pursuant to the federal Social Security Act, §1905(c)(d), as codified in 42 U.S.C. §1396d, which are contained in 42 C.F.R. pt. 483, subpt. D, §410 – 480.

Hospital: Certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements outlined in Iowa Administrative Code.

Nursing Facility: Licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

ICF/ID: Meets the federal standards for intermediate care facilities for persons with an intellectual disability established pursuant to the federal Social Security Act, §1905(c)(d), as codified in 42 U.S.C. §1396d, which are contained in 42 C.F.R. pt. 483, subpt. D, §410 – 480.

Certificate (specify):

Other Standard (specify):

Providers must:

- (1) Be at least 18 years of age.
- (2) Be qualified by training in accordance with the Iowa Administrative Code to carry out the person's service plan pursuant to department-approved service planning process.
- (3) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

(4)

(5) Not be the recipient of respite services paid through home and community-based services on behalf of the person who receives home and community-based services.

Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually: -The person's name, birth date, age, 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 person's physician and the spouse, guardian, or primary caregiver. -The person's medical issues, including allergies. -The person's daily schedule which includes the person's preferences in activities or foods or any other special concerns.

(2) 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 members and the public. Nonprescription medications shall be labeled with the person'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: -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. -

(4) Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian, or primary caregiver upon request.

(5) Ensuring the safety and privacy of the person. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

(6) A facility providing respite shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the person'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. 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:

Camp

Provider Qualifications

License (specify):

Certificate (specify):

Respite care providers certified in accordance with Iowa Administrative Code 441-77.33(6). 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. Can visit www.ACAcamps.org/accreditation for more information.

Other Standard (specify):

Providers must:

- (1) Be at least 18 years of age.
- (2) Be qualified by training in accordance with the Iowa Administrative Code to carry out the person's service plan pursuant to department-approved service planning process.
- (3) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.
- (4)
- (5) Not be the recipient of respite services paid through home and community-based services on behalf of the person who receives home and community-based services.

Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually: -The person's name, birth date, age, 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 person's physician and the spouse, guardian, or primary caregiver. -The person's medical issues, including allergies. -The person's daily schedule which includes the person's preferences in activities or foods or any other special concerns.
- (2) 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 members and the public. Nonprescription medications shall be labeled with the person'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: -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. -
- (4) Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian, or primary caregiver upon request. -
- (5) Ensuring the safety and privacy of the person. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
- (6) A facility providing respite shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the person'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. 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 - Residential Care Facility

Provider Qualifications**License (specify):**

Residential care facilities licensed and in good standing by the Department of Inspections and Appeals under Iowa Administrative Code 481.

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

Providers must:

- (1) Be at least 18 years of age.
- (2) Be qualified by training in accordance with the Iowa Administrative Code to carry out the person's service plan pursuant to department-approved service planning process.
- (3) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.
- (4) Not be the recipient of Respite services paid through home and community-based services on behalf of the person who receives home and community-based services.

Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually: -The person's name, birth date, age, 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 person's physician and the spouse, guardian, or primary caregiver. -The person's medical issues, including allergies. -The person's daily schedule which includes the person's preferences in activities or foods or any other special concerns.
- (2) 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 members and the public. Nonprescription medications shall be labeled with the person'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: -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. -
- (4) Documenting activities and times of Respite. This documentation shall be made available to the spouse, guardian, or primary caregiver upon request.
- (5) Ensuring the safety and privacy of the person. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
- (6) A facility providing Respite shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the person'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. 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:

Assisted Living Program

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Assisted Living programs licensed and in good standing by the Iowa Department of Inspections Appeals and Licensing as defined in Iowa Administrative Code 481.

Other Standard (*specify*):

Providers must:

- (1) Be at least 18 years of age.
- (2) Be qualified by training in accordance with the Iowa Administrative Code to carry out the person's service plan pursuant to department-approved service planning process.
- (3) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.
- (45) Not be the recipient of Respite services paid through home and community-based services on behalf of the person who receives home and community-based services.

Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually: -The person's name, birth date, age, 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 person's physician and the spouse, guardian, or primary caregiver. -The person's medical issues, including allergies. -The person's daily schedule which includes the person's preferences in activities or foods or any other special concerns.
- (2) 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 members and the public. Nonprescription medications shall be labeled with the person'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: -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. -
- (4) Documenting activities and times of Respite. This documentation shall be made available to the spouse, guardian, or primary caregiver upon request.
- (5) Ensuring the safety and privacy of the person. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
- (6) A facility providing Respite shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the person'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. 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

08/15/2025

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:

HCBS Certified Respite Provider

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

Certified to provide respite by the Department's Home and Community Based Services Quality Oversight Unit as outlined in Iowa Administrative Code 441.

Other Standard (specify):

Providers must:

- (1) Be at least 18 years of age.
- (2) Be qualified by training in accordance with the Iowa Administrative Code to carry out the person's service plan pursuant to department-approved service planning process.
- (3) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.
- (4) Not be the recipient of respite services paid through home and community-based services on behalf of the person who receives home and community-based services.

Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually: -The person's name, birth date, age, 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 person's physician and the spouse, guardian, or primary caregiver. -The person's medical issues, including allergies. -The person's daily schedule which includes the person's preferences in activities or foods or any other special concerns.
 - (2) 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 members and the public. Nonprescription medications shall be labeled with the person'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: -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. -
 - (4) Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian, or primary caregiver upon request. -
 - (5) Ensuring the safety and privacy of the person. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
 - (6) A facility providing respite shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.
- Respite provided outside the person'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. 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:

Foster Care Facility

Provider Qualifications

License (specify):

Group foster care facilities for children licensed and in good standing by the department according to Iowa Administrative Code 441.

Certificate (specify):

Other Standard (specify):

Providers must:

- (1) Be at least 18 years of age.
- (2) Be qualified by training in accordance with the Iowa Administrative Code to carry out the person's service plan pursuant to department-approved service planning process.
- (3) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.
- (4) Not be the recipient of Respite services paid through home and community-based services on behalf of the person who receives home and community-based services.

Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually: -The person's name, birth date, age, 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 person's physician and the spouse, guardian, or primary caregiver. -The person's medical issues, including allergies. -The person's daily schedule which includes the person's preferences in activities or foods or any other special concerns.
- (2) 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 members and the public. Nonprescription medications shall be labeled with the person'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: -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. -
- (4) Documenting activities and times of Respite. This documentation shall be made available to the spouse, guardian, or primary caregiver upon request.

- (5) Ensuring the safety and privacy of the person. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
- (6) A facility providing Respite shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.
- Respite provided outside the person'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. 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:

Home Care Agency

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

Eligible home care agencies are those that meet the conditions set forth in Iowa Administrative Code 441--77.33(4).

- a. Certified as a home health agency under Medicare, or
- b. Authorized to provide similar services through a contract with HHS for local public health services. The agency must provide a current local public health services contract number.

Other Standard (specify):

Providers must:

- (1) Be at least 18 years of age.
- (2) Be qualified by training in accordance with the Iowa Administrative Code to carry out the person's service plan pursuant to department-approved service planning process.
- (3) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.
- (4) Not be the recipient of Respite services paid through home and community-based services on behalf of the person who receives home and community-based services.

Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually: -The person's name, birth date, age, 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 person's physician and the spouse, guardian, or primary caregiver. -The person's medical issues, including allergies. -The person's daily schedule which includes the person's preferences in activities or foods or any other special concerns.
- (2) 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 members and the public. Nonprescription medications shall be labeled with the person'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: -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. –

(4) Documenting activities and times of Respite. This documentation shall be made available to the spouse, guardian, or primary caregiver upon request.

(5) Ensuring the safety and privacy of the person. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

(6) A facility providing Respite shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the person'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. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Child Care Facility

Provider Qualifications

License (specify):

Childcare facilities that are defined as childcare centers or child development homes licensed in accordance with Iowa Administrative Code 441

Certificate (specify):

Other Standard (specify):

Providers must:

- (1) Be at least 18 years of age.
- (2) Be qualified by training in accordance with the Iowa Administrative Code to carry out the person's service plan pursuant to department-approved service planning process.
- (3) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.
- (5) Not be the recipient of respite services paid through home and community-based services on behalf of the person who receives home and community-based services.

Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually: -The person's name, birth date, age, 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 person's physician and the spouse, guardian, or primary caregiver. -The person's medical issues, including allergies. -The person's daily schedule which includes the person's preferences in activities or foods or any other special concerns.

- (2) 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 members and the public. Nonprescription medications shall be labeled with the person'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: -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. –
- (4) Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian, or primary caregiver upon request.
- (5) Ensuring the safety and privacy of the person. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
- (6) A facility providing respite shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.
- Respite provided outside the person'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. Respite in these locations shall not exceed 72 continuous hours.

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

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

Frequency of Verification:

Every five years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

Provider Type:

Adult Day Care Provider

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

Adult Day Care Providers certified by the Iowa Department of Inspections and Appeals under Iowa Administrative Code 481.

Other Standard (specify):

Providers must:

- (1) Be at least 18 years of age.
- (2) Be qualified by training in accordance with the Iowa Administrative Code to carry out the person's service plan pursuant to department-approved service planning process.
- (3) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.
- (4)
- (5) Not be the recipient of respite services paid through home and community-based services on behalf of the person who receives home and community-based services.

Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually: -The person's name, birth date, age, 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 person's physician and the spouse, guardian, or primary caregiver. -The person's medical issues, including allergies. -The person's daily schedule which includes the person's preferences in activities or foods or any other special concerns.
 - (2) 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 members and the public. Nonprescription medications shall be labeled with the person'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: -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. -
 - (4) Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian, or primary caregiver upon request. -
 - (5) Ensuring the safety and privacy of the person. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
 - (6) A facility providing respite shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.
- Respite provided outside the person'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. 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:

Home Health Agency

Provider Qualifications

License (specify):

Certificate (specify):

Home health agencies certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891), and, unless exempted under Iowa Administrative Code, have submitted a surety bond.

Other Standard (specify):

Providers must:

- (1) Be at least 18 years of age.
- (2) Be qualified by training in accordance with the Iowa Administrative Code to carry out the person's service plan pursuant to department-approved service planning process.
- (3) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

(4) Not be the spouse or guardian of the person or a parent or stepparent of a person aged 17 or under.

(5) Not be the recipient of respite services paid through home and community-based services on behalf of the person who receives home and community-based services.

Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually: -The person's name, birth date, age, 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 person's physician and the spouse, guardian, or primary caregiver. -The person's medical issues, including allergies. -The person's daily schedule which includes the person's preferences in activities or foods or any other special concerns.

(2) 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 members and the public. Nonprescription medications shall be labeled with the person'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: -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. -

(4) Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian, or primary caregiver upon request. -

(5) Ensuring the safety and privacy of the person. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

(6) A facility providing respite shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the person'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. Respite in these locations shall not exceed 72 continuous hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:**

03 Supported Employment

Sub-Category 1:

03010 job development

Category 2:

03 Supported Employment

Sub-Category 2:

03021 ongoing supported employment, individual

Category 3:

03 Supported Employment

Sub-Category 3:

03022 ongoing supported employment, group

Category 4:

03 Supported Employment

Sub-Category 4:

03030 career planning

Service Definition (Scope):

Supported Employment (SE) services are provided to, or on behalf of, the person to enable the person to obtain and maintain an individualized job in competitive employment, customized employment, or self-employment in an integrated work setting in the general workforce. These services include:

Individual SE (including Supported Self-Employment), Long-Term Job Coaching, Small Group SE, Individual Placement and Support (IPS)

SE's expected outcome 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.

SE services shall take place in integrated work settings. The person's home can be considered an integrated work setting for self-employment. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where persons are paid to produce 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.

Individualized employment strategies can include customized employment, person placement and support, and supported self-employment.

SE service activities are personalized and may include any combination of the following:

Benefits education, Career exploration (e.g., tours, informational interviews, job shadows), Employment assessment, Assistive technology (AT) assessment, Trial work experience, Person-centered employment planning, Development of visual/traditional résumés, Job-seeking skills training and support, Outreach to prospective employers on behalf of the person (e.g., job development; negotiation with prospective employers to customize, create, or carve out a position for the person; employer needs analysis), Job analysis (e.g., worksite assessment or job accommodations evaluation), Identifying and arranging transportation, Career advancement services (e.g., assisting a person in making an upward career move or seeking promotion from an existing employer), Re-employment services (if necessary due to job loss), Financial literacy and asset development, Other employment support services deemed necessary to enable the person to obtain employment, Systematic instruction and support during initial on-the-job training, including initial on-the-job training to stabilization, Engagement of natural supports during initial period of employment, Implementation of AT solutions during initial period of employment, Transportation of the person during service hours.

Individualized 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 person earns income equal to or exceeds the average income for the chosen business within a reasonable period.

To establish self-employment, activities may include:

Aid to the person in identifying potential business opportunities, Assistance in the development of a business plan, including

identifying potential sources of business financing and other assistance in developing and launching a business, Identification of the long-term supports necessary for the person to operate the business. Long-term job coaching. Long-term job coaching is support provided to, or on behalf of, the person that enables the person to maintain an individualized job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce. Ongoing identification of the supports necessary for the person to operate the business; ongoing assistance, counseling and guidance to maintain and grow the business; and ongoing benefits of education and support also included.

Long-term job coaching services are provided to or on behalf of persons who need support because of their disabilities and are unlikely to maintain and advance in-person employment without the provision of support. Long-term job coaching services shall provide personalized and ongoing support contacts at intervals necessary to promote successful job retention and advancement. Transition to Long-Term Job Coaching, if needed, is an expected outcome. Long-term job coaching services are designed to assist the person with learning and retaining individualized employment, resulting in workplace integration, which reduces long-term job coaching over time.

Services are personalized, and person-centered service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the person:

Job analysis, Job training and systematic instruction, Training and support for the use of AT/adaptive aids, Engagement of natural supports, Transportation coordination, Job retention training and support, Benefits education

and ongoing support, Supports for career advancement, financial literacy and asset development, Employer consultation and support, Negotiation with employer on behalf of the person (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).

Other workplace support services may include services not specifically related to job skill training that enable the waiver person to be successful in integrating into the job setting, Transportation of the person during service hours, 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.

The hours of support tier assignment for long-term job coaching are based on the person's identified needs as documented in the person-centered 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. Small-group SE services must be provided to promote integration into the workplace and interaction between persons 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 person community employment.

Small-group SE services are expected to enable the person to make reasonable and continued progress toward personal employment. Participation in small-group SE services is not a prerequisite for SE services. The outcome of this service is sustained paid employment experience, skill development, career exploration, and planning leading to referral for services to obtain individualized, integrated employment or self-employment for which a person 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 persons without disabilities.

Small-group SE services shall take place in integrated, community-based nonresidential settings separate from the person's residence.

Small-group SE services may include any combination of the following activities:

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

Providers delivering this service via the Telehealth service delivery option must demonstrate policies and procedures that include:

•HIPAA-compliant platforms; Support given when a person's needs include accessibility, translation, or has limited auditory or visual capacities; Have a contingency plan for the provision of services if technology fails; Professionals do not practice outside of their respective scope; and Assessment of persons and caregivers that identifies a person's ability to participate and outlines any accommodations needed while using Telehealth.

The person-centered service plan (PCSP) will address how the person's needs are met. Services must be authorized in the PCSP and monitored by the case manager.

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

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

Supported Employment is comprised of four service types.

- A unit of service for Individual Supported Employment is one hour.
- A unit of service for Small Group Employment is 15 minutes.
- A unit of service for Long-Term Job Coaching is a monthly unit of service or hourly for persons requiring 25 or more hours of service per month. The hours of support for Long-Term Job Coaching are based on the identified needs of the person as documented in the person's service plan and adjusted when higher support needs are determined based on the hours of support the person requires each month.

A person's 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).

Limitations. Supported Employment services are limited as follows:

- 1) The total monthly cost of all Supported Employment services may not exceed the limits in Iowa Administrative Code 441.79 and are subject to change annually .
- 2) Individual Supported Employment
 - a. Initial authorization: Not to exceed 40 hourly units.
 - b. Extended authorization: Not to exceed 20 hourly units
 - c. One initial and, if necessary, one extended authorization permitted per year not to exceed a total of 60 hourly units per year

Excluded services and costs. Services, activities, costs, and time that are not covered and for which payment shall not be made include 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 person receiving individual Supported Employment or long-term job coaching services.
- 2) Incentive payments, not including payments for coworker supports, are 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 person's Supported Employment program.
- 5) Services involved in placing and stabilizing persons 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 person specific.
- 9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. For persons choosing the Consumer Choices Option (CCO), the individual budget limit will be based on the person's authorized service plan and the need for the services available to be converted to the CCO budget.

The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services are appropriately authorized in the person's person-centered service plan as needed. Where there is a potential for overlap, services must first be exhausted under Section 110 of the Rehabilitation Act of 1973. The first line of prevention of duplicative billing for similar types of services, such as family and community support service, is the person's case manager.

The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as described in the person-centered service plan. The department also conducts post audit reviews of providers to review the billing of providers to assure that the services provided have documentation to support the billing.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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

Remote/via Telehealth

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 Employment Provider

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:

Supported Employment Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Providers accredited by CQL, International Center for Clubhouse Development, Joint Commission on Accreditation of Healthcare, Council on Accreditation for Services for Families and Children or CARF as an organizational employment service provider or a community employment service provider in accordance with Iowa Administrative Code 441 Chapter 77.

Providers responsible for the payroll of persons receiving supports 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) Vacation, sick leave, and holiday compensation.
- (3) Procedures for payment schedules and pay scale.

- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

Individuals may not provide Supported Employment services except when the services are purchased through the consumer choices option.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Equipment

HCBS Taxonomy:

Category 1:

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):**

Specialized Medical Equipment includes medically necessary items for personal use by the person which provide for the health and safety of the person, are not ordinarily covered by Medicaid, are not funded under Section 110 of the Rehabilitation Act of 1973 or the Persons with Disabilities Education Act (20 U.S.C. 1401 et seq.), and are not provided on a voluntary means.

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and consistent with waiver objectives to avoid institutionalization, excluding those items that are not of direct medical or remedial benefit to the person or are duplicative of services contained in the state plan. All items shall meet applicable standards of manufacture design and installation. This includes but is not limited to:

- 1) Electronic aids and organizers,
- 2) Electronic medication dispensing devices,
- 3) Communication devices,
- 4) Bath aids,
- 5) Noncovered environmental control units, and
- 6) Bath chairs.

This includes repair and maintenance of items purchased through the waiver in addition to initial purchase cost.

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager.

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

A unit of service is one occurrence. The annual limit is published in Iowa Administrative Code which is subject to change on a yearly basis.

The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services are appropriately authorized in the person's person-centered service plan as needed. Where there is a potential for overlap, services must first be exhausted under Section 110 of the Rehabilitation Act of 1973. The first line of prevention of duplicative billing for similar types of services, such as family and community support service, is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as described in the person-centered service plan.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR requests are approved by the Department of Health and Human Services direct

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

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Remote/via Telehealth****Specify whether the service may be provided by (check each that applies):**

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Equipment and Supply dealers

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Medical Equipment and Supply dealers

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Medical equipment and supply dealer certified to participate in the Medicaid program as defined by Iowa Administrative Code 441 Chapter 77.

Other Standard (*specify*):

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

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Management Service

HCBS Taxonomy:**Category 1:**

12 Services Supporting Self-Direction

Sub-Category 1:

12010 financial management services in support of self-dir

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

The Financial Management Service (FMS) is necessary for all persons 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 personalized budgets are managed and distributed according to the budget developed by each person and to facilitate the employment of service workers by persons. The Iowa Department of Human Services will designate the Financial Management Service entities as organized health care delivery systems.

Responsibilities of the FMS. The FMS 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 person's budget.
- 3) Enter the person's budget into the web-based tracking system chosen by the department and enter expenditures as they are paid.
- 4) Provide real-time person budget account balances for the person, 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 Iowa Administrative Code.
- 6) Verify for the person an employee's citizenship or alien status.
- 7) Assist the person with fiscal and payroll-related responsibilities including, but not limited to:
 - a) Verifying that hourly wages comply with federal and state labor rules.
 - b) Collecting and processing timecards.
 - c) 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.
 - d) Computing and processing other withholdings, as applicable.
 - e) Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 - f) Preparing and issuing employee payroll checks.
 - g) Preparing and disbursing IRS Forms W-2 and W-3 annually.
 - h) Processing federal advance earned income tax credit for eligible employees.
 - i) Refunding over-collected FICA, when appropriate.
 - j) Refunding over-collected FUTA, when appropriate.
- 8) Assist the person in completing required federal, state, and local tax and insurance forms.
- 9) Establish and manage documents and files for the person and the person's employees.
- 10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the person's budget. Keep records of all timecards and invoices for each person for a total of five years.
- 11) Provide to the department, the Independent Support Broker, and the person 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 person 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 FMS.
- 17) Assist in implementing the state's quality management strategy related to the FMS.
- 18) Be able to interface with the tracking system(s) chosen by the Iowa Department of Health and Human Services.

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager

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

A unit of service is monthly, billed at a per person per month rate as contained in the Iowa Administrative Code and subject to change on a yearly basis.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Service

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Financial Management Service

Provider Category:

Agency

Provider Type:

Financial Management Service

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

As defined in Iowa Administrative Code 441, the financial institution shall:

(1) Either:

a. 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

b. 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).

(2) The financial institution shall complete a financial management readiness review and certification conducted by the

department or its designee.

(3) The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

(4) 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:

12 Services Supporting Self-Direction

Sub-Category 1:

12020 information and assistance in support of self-direction

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Independent Support Brokerage (ISB) service is an optional service for members who choose the self-direction option. When the member chooses the ISB service, the service is included in the person's budget. The ISB will be chosen and hired by the person. The ISB will work with the person to offer technical assistance and expertise for selecting and hiring employees and/or providers and purchasing supports.

When a person does not choose to access an Independent Support Broker, the case manager will work with the person 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 ISB shall perform the following services as directed by the person or the person's representative:

- 1) Assist the person with developing the person's initial and subsequent individualized budgets and with making any changes to the individualized budget. The person shall be informed of the individual budget amount from the development of the person-centered service plan. The case manager oversees the services authorized to develop the monthly CCO budget.
- 2) Have monthly contact with the person for the first four months of implementation of the initial budget and have quarterly contact thereafter. If a person needs additional support brokerage service, the person can seek a Waiver of Administrative Rule.
- 3) Support the completion of 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 person.
- 5) Assist the person with determining whether a potential employee meets the qualifications necessary to perform the job.
- 6) Assist the person with obtaining a signed consent from a potential employee to conduct background checks if requested by the person.
- 7) Assist the person with negotiating with entities providing services and supports if requested by the person.
- 8) Assist the person with contracts and payment methods for services and supports if requested by the person.
- 9) Document in writing every contact the broker has with the person. Contact documentation shall include information on the extent to which the person's budget has addressed the person's needs and the satisfaction of the person. The case manager, the Financial Management Service and the department may review this documentation at any time.

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager.

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

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

The unit is hourly. The rates for allowable provider types are published in the Iowa Administrative Code and subject to change on a yearly basis.

When an Independent Support Broker is chosen, the service plan shall not exceed a maximum of 30 units per year.

Independent Support Brokers may participate in the person-centered planning process but the case manager is responsible for the development of the person-centered service plan.

The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services are appropriately authorized in the person's person-centered service plan as needed. Where there is a potential for overlap, services must first be exhausted under Section 110 of the Rehabilitation Act of 1973. The first line of prevention of duplicative billing for similar types of services, such as family and community support service, is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as described in the person-centered service plan.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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

Remote/via Telehealth

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*):

People who elect the consumer choices option shall may work with an Independent Support Broker who meets the following qualifications:

- (1) The broker must be at least 18 years of age.
- (2) The broker shall not be the person'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.
- (3) The broker shall not provide any other paid service to the person receiving supports.
- (4) The broker shall not work for an individual or entity that is providing services to the person receiving supports.
- (5) The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the person receiving supports.
- (6) The broker must complete Independent Support Brokerage training approved by the department.

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

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:

Other Supports for Participant Direction

Alternate Service Title (if any):

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

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 person's person-centered 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 person's budget without compromising the person's health and safety.
- 4) Be provided to the person or directed exclusively toward the benefit of the person.
- 5) Be the least costly to meet the person's needs.
- 6) Not be available through another source.

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

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager.

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 person-centered service plan and the need for the services available to be converted. A utilization adjustment rate will be applied to the individual budget amount.

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

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting, or similar venue expenses other than the costs of approved services the person needs while attending the conference, meeting, or similar venue.
4. Costs associated with shipping items to the person.
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 person's service plan.
22. Vacation expenses, other than the costs of approved services the person needs while on vacation.
23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member's service plan.
24. Residential services provided to three or more members living in the same residential setting.

The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services are appropriately authorized in the person's person-centered service plan as needed. Where there is a potential for overlap, services must first be exhausted under Section 110 of the Rehabilitation Act of 1973. The first line of prevention of duplicative billing for similar types of services, such as family and community support service, is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as described in the person-centered service plan.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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

Remote/via Telehealth

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

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:

Provider Type:**Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

C-1/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:

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:**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):

Service activities performed to help a person with self-care tasks which the person would typically do independently if the person were otherwise able. This service may be provided in a private residence, workplace, or in Assisted Living.

Attendant Care activities may include helping the person with any of the following nonskilled service activities:

- 1) Dressing.
- 2) Bath, shampoo, hygiene, and grooming.
- 3) Access to and from bed or a wheelchair, transferring, ambulation and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.
- 4) Toilet assistance, including bowel, bladder, and catheter assistance.
- 5) Meal preparation, cooking, eating, and feeding but not the cost of meals themselves.
- 6) Housekeeping services which are essential to the person's health care at home, including shopping and laundry.
- 7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete medication aide course administered by an area community college.
- 8) Wound care.
- 9) Assistance needed to go to or return from a place of employment and assistance with job related tasks while the person is on the job site. The cost of transportation for the person and assistance with understanding or performing the essential job functions are not included in person 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 person, through interpreting and reading services and use of Assistive Devices for communication.
- 12) Supporting access to and use of transportation essential to the health and welfare of the person. The cost of the transportation is not included. "Usual caregiver" means unpaid person or persons who reside with the member and are available on a 24-hour per-day basis to assume responsibility for the care of the member.

This service is separate and distinct from Home Health Aide and Home Maintenance Support services; and is monitored by the case manager as part of inclusion in the person plan.

Attendant Care is one of multiple waiver services that may be used to create a self-directed budget amount through Consumer Choices Option (CCO). When Attendant Care is authorized in the CCO budget, the case manager is responsible for ensuring that service needs are met and there is no duplication of services.

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager.

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

A unit of service is 15 minutes billed in whole units. The upper limits for allowable provider types are published in the Iowa Administrative Code. The rates are subject to change on a yearly basis.

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

The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services are appropriately authorized in the person's person-centered service plan as needed.

Where there is a potential for overlap, services must first be exhausted under Section 110 of the Rehabilitation Act of 1973. The first line of prevention of duplicative billing for similar types of services is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as ordered. The IoWANS system generates a review report to assist the case manager. The report identifies all services that are billed for a specific time period (ex. one month). The case manager can view the service billed to the person, the amount of the service billed, and the provider. The case manager can compare what is billed by the provider to what is ordered in the service plan.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Area Agency on Aging
Agency	Community Action Agency
Agency	Adult Day Care provider
Agency	Assisted Living Program
Agency	Community Business
Agency	Home Health Agency
Agency	Supported Community Living Provider
Agency	Home Care Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Area Agency on Aging

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Providers subcontracting with the Area Agencies on Aging or with letters of approval from the Area Agencies on Aging that the organization is qualified to provide attendant care services.

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 for ensuring that the contractor is qualified and reliable. Case managers are responsible for monitoring service provision to ensure services are provided in a safe and effective manner.

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved

service planning process.

(3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.

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

The service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

CCommunity action agencies designated in Iowa Code section 216A.93 and governed by a board of directors in accordance with Iowa Code 216A.94. Community action agencies:

- (1) Plan and implement strategies to alleviate the conditions of poverty and encourage self-sufficiency for citizens in its service area and in Iowa.
- (2) Obtain and administer assistance from available sources on a common or cooperative basis, in an attempt to provide additional opportunities to low-income persons.
- (3) Establish effective procedures by which the concerned low-income persons and area residents may influence the community action programs affecting them by providing for methods of participation in the implementation of the community action programs and by providing technical support to assist persons to secure assistance available from public and private sources.
- (4) Encourage and support self-help, volunteer, business, labor, and other groups, and organizations to assist public officials and agencies in supporting a community action program.

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 for ensuring that the contractor is qualified and reliable. Case managers are responsible for monitoring service provision to ensure services are provided in a safe and effective manner.

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served.

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: Attendant Care

Provider Category:

Agency

Provider Type:

Adult Day Care provider

Provider Qualifications

License (specify):

Certificate (specify):

Adult Day Care Providers certified by the Iowa Department of Inspections and Appeals under Iowa Administrative Code 481.

Other Standard (specify):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served.

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: Attendant Care**

Provider Category:

Agency

Provider Type:

Assisted Living Program

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

Assisted Living programs certified by the Iowa Department of Inspections and Appeals under Iowa Administrative Code 481.

Other Standard (specify):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served.

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: Attendant Care**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 must submit verification of current liability and workers' compensation coverage.

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served

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: Attendant Care****Provider Category:**

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License (specify):**

Certificate (specify):

Home health agencies certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891), and, unless exempted under Iowa Administrative Code, have submitted a surety bond.

Other Standard (specify):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served.

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: Attendant Care

Provider Category:

Agency

Provider Type:

Supported Community Living Provider

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 in accordance with Iowa Administrative Code 441.

Other Standard (specify):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served.

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: Attendant Care

Provider Category:

Agency

Provider Type:

Home Care Provider

Provider Qualifications

License (specify):

Certificate (specify):

Home care providers that have a contract with the HHS or have written certification from HHS stating they meet the home care standards and requirements set forth in Iowa Administrative Code 641.

Other Standard (specify):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Enabling Technology for Remote Support

HCBS Taxonomy:

Category 1:

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. The annual per person limitation for Enabling Technology is published in Iowa Administrative Code which is subject to change on a yearly basis.

Excluded services and costs. Services, activities, costs, and time that are not covered include repair and maintenance of the technology.

The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services are appropriately authorized in the person's person-centered service plan as needed. Where there is a potential for overlap, services must first be exhausted under Section 110 of the Rehabilitation Act of 1973. The first line of prevention of duplicative billing for similar types of services, such as family and community support service, is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as described in the person-centered service plan.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enabling Technology/Equipment providers that meet the Enabling Technology service standards
Individual	Enabling Technology/Equipment providers that meet the Enabling Technology service standards
Individual	Enabling Technology Assessment providers
Agency	Enabling Technology Assessment providers
Agency	Supported Community Living Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Enabling Technology for Remote Support

Provider Category:

Agency

Provider Type:

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

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

The support planning team will identify the person(s) or entity experienced in the area of Enabling Technology and its application for people with disabilities as qualified to provide and ensure that:

- a) an evaluation of the participant's need for an assessment of potential for successful utilization of enabling devices occurs;
- b) the appropriate and cost-effective device is selected from available options;
- c) the appropriate device is procured;
- d) training and technical assistance to the participant, caregiver and staff for the proper utilization of the device occurs; and
- e) appropriate evaluation methods are developed to assure that the intended outcome(s) of the technology is achieved.

Enabling technology equipment services must provide a cost-effective, appropriate means of meeting the needs defined in the member's person-centered service plan.

All items shall meet applicable standards of manufacture, design and installation.

Providers delivering Enabling Technology needs must be one of the following professionals:

- Providers enrolled to deliver HCBS BI or ID waiver Supported Community Living
- Providers enrolled to deliver HCBS Habilitation Home-Based Habilitation
- Other qualified by training or experience to provide enabling technology.

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

Iowa Department of Health and Human Services, Iowa Medicaid

Frequency of Verification:

Every five years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Enabling Technology for Remote Support

Provider Category:

Individual

Provider Type:

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

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

The interdisciplinary team will identify the person(s) or entity experienced in the area of Enabling technology and its application for people with disabilities as qualified to provide and ensure that:

- a) an evaluation of the participant's need for an assessment of potential for successful utilization of enabling devices occurs;
- b) the appropriate and cost-effective device is selected from available options;
- c) the appropriate device is procured;

d) training and technical assistance to the participant, caregiver and staff for the proper utilization of the device occurs; and

e) appropriate evaluation methods are developed to assure that the intended outcome(s) of the technology is achieved.

Enabling technology equipment services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's support plan.

All items shall meet applicable standards of manufacture, design and installation.

Providers delivering Enabling Technology needs must be one of the following professionals:

- Provider enrolled to deliver HCBS BI or ID waiver Supported Community Living
- Providers enrolled to deliver HCBS Habilitation Home-Based Habilitation
- Other qualified by training or experience to provide enabling technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Enabling Technology for Remote Support

Provider Category:

Individual

Provider Type:

Enabling Technology Assessment providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The support planning team will identify the person(s) or entity experienced in the area of enabling technology and its application for people with disabilities as qualified to provide and ensure that:

- a) an evaluation of the participant's need for an assessment of potential for successful utilization of enabling devices occurs;
- b) the appropriate and cost-effective device is selected from available options;
- c) the appropriate device is procured;
- d) training and technical assistance to the participant, caregiver and staff for the proper utilization of the device occurs; and
- e) appropriate evaluation methods are developed to assure that the intended outcome(s) of the technology is achieved.

Providers evaluating enabling technology needs must be one of the following professionals:

- Certification through the Rehabilitation Engineering and Assistive Technology Society
- Certification through California State University Northridge's Assistive Technology Program
- Occupational therapists must currently be registered by the American Occupational Therapy Association as an occupational therapist
- Physical therapists must be a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent and licensed in Iowa.
- Speech-language pathologists must have a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association.

- Other professionals qualified by training and or experience to conduct technology assessments.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Enabling Technology for Remote Support

Provider Category:

Agency

Provider Type:

Enabling Technology Assessment providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The interdisciplinary team will identify the person(s) or entity experienced in the area of enabling technology and its application for people with disabilities as qualified to provide and ensure that:

- a) an evaluation of the participant's need for an assessment of potential for successful utilization of enabling devices occurs;
- b) the appropriate and cost-effective device is selected from available options;
- c) the appropriate device is procured;
- d) training and technical assistance to the participant, caregiver and staff for the proper utilization of the device occurs; and
- e) appropriate evaluation methods are developed to assure that the intended outcome(s) of the technology is achieved.

Providers assessing Enabling Technology needs must be one of the following professionals:

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Human Services, Iowa Medicaid

Frequency of Verification:

Every five years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Enabling Technology for Remote Support****Provider Category:**

Agency

Provider Type:

Supported Community Living Provider

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 in accordance with Iowa Administrative Code 441.

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 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: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Family Training Services

HCBS Taxonomy:**Category 1:**

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10060 counseling

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Family Training services are face-to-face mental health services provided to the person and the family with whom the person lives (or who routinely provides care to the person) to increase the person's or family members' capabilities to maintain and care for the person in the community.

"Family" may include spouse, children, parents, siblings, friends, or in-laws of the person. It does not include people who are employed to care for the person. Counseling may include the use of treatment regimens as specified in the person treatment plan. Periodic training updates may be necessary to safely maintain the person in the community.

Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified professional who are employees of a qualified provider.

Family Training may include helping the person or family with:

- Crisis prevention
- Coping strategies
- Stress reduction
- Management of depression
- Alleviation of psychosocial isolation

Support in coping with the effects of a disability

Providers delivering this service via the Telehealth service delivery option must demonstrate policies and procedures that include:

- HIPAA compliant platforms;
- Support given when a person's needs include accessibility, translation, or has limited auditory or visual capacities;
- Have a contingency plan for provision of services if technology fails;
- Professionals do not practice outside of their respective scope; and
- Assessment of persons and caregivers that identifies a person's ability to participate in and outlines any accommodations needed while using Telehealth.

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

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager.

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

A unit of service is 15 minutes.

Payment for group counseling is based on a group rate divided by six (6) or the actual number of persons participating in the group if the number of participants exceeds six individuals.

The first line of prevention of duplicative billing for similar types of services is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as ordered.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Mental Health Service Provider
Agency	Hospice Provider
Agency	Agencies which are accredited by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider
Agency	Community Mental Health Centers
Individual	Mental Health Professional

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Training Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

Certificate (specify):

Home health agencies certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891), and, unless exempted under Iowa Administrative Code, have submitted a surety bond.

Other Standard (specify):

Family Training providers shall be required to have experience with or training regarding the special needs of persons receiving HCBS supports. In addition, they must meet the following requirements:

- (1) Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified professional as defined in Iowa Administrative Code 441. Formal assessment of a person's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- (2) Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified professional as defined in Iowa Administrative Code 441 and who are employees of a qualified provider.

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

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

Frequency of Verification:

Every five years.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Family Training Services

Provider Category:

Agency

Provider Type:

Mental Health Service Provider

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

Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in Iowa Administrative Code 441. "Mental health service provider" means an organization whose services are established to specifically address mental health services to individuals or the administration of facilities in which these services are provided.

Family Training providers shall be required to have experience with or training regarding the special needs of persons receiving HCBS supports. In addition, they must meet the following requirements:

- (1) Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified professional as defined in Iowa Administrative Code 441. Formal assessment of a person's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- (2) Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified professional as defined in Iowa Administrative Code 441 and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Training Services

Provider Category:

Agency

Provider Type:

Hospice Provider

Provider Qualifications**License (specify):**

Agencies which are licensed as meeting the hospice standards and requirements set forth in Department of Inspections and Appeals Iowa Administrative Code 481 Chapter 53.

Certificate (specify):

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

Other Standard (specify):

Family Training providers shall be required to have experience with or training regarding the special needs of persons receiving HCBS supports. In addition, they must meet the following requirements:

- (1) Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified professional as defined in Iowa Administrative Code 441. Formal assessment of a person's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- (2) Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified professional as defined in Iowa Administrative Code 441 and who are employees of a qualified provider.

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

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Training Services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

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

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

Family Training providers shall be required to have experience with or training regarding the special needs of persons receiving HCBS supports. In addition, they must meet the following requirements:

- (1) Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified professional as defined in Iowa Administrative Code 441. Formal assessment of a person's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- (2) Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified professional as defined in Iowa Administrative Code 441 and who are employees of a qualified provider.

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

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

Frequency of Verification:

Every five years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Family Training Services****Provider Category:**

Agency

Provider Type:

Community Mental Health Centers

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

Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in Iowa Administrative Code 441

Other Standard (specify):

PCommunity mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

Family Training providers shall be required to have experience with or training to work with persons receiving HCBS supports. In addition, they must meet the following requirements:

- (1) Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified professional as defined in Iowa Administrative Code 441. Formal assessment of a person's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- (2) Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified professional as defined in Iowa Administrative Code 441 and who are employees of a qualified provider.

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

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

Frequency of Verification:

Every five years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Family Training Services****Provider Category:**

Individual

Provider Type:

Mental Health Professional

Provider Qualifications**License (specify):**

Mental health professionals licensed pursuant to 645 Chapter 31, 240, or 280 or possessing an equivalent license in another state.

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

Family Training providers shall be required to have experience with or training to work with persons receiving HCBS supports. In addition, they must meet the following requirements:

- (1) Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified professional as defined in Iowa Administrative Code 441. Formal assessment of a person's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- (2) Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified professional as defined in Iowa Administrative Code 441 and who are employees of a qualified provider.

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

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

Frequency of Verification:

Every 5 years

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

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

Service Type:

Other Service

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

Service Title:

Home and Vehicle Modification

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

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 person's home or vehicle that directly address the person's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the person and enable the person to function with greater independence in the home or vehicle.

Home and Vehicle Modifications are not furnished to adapt living arrangements that are owned or leased by providers of waiver services, including Assisted Living facilities. Home and vehicle repairs are also excluded. A repair is allowed to equipment purchased using the waiver when it is the less costly alternative to replacement. The purchase or lease of a motorized vehicle and regularly scheduled upkeep and maintenance of a vehicle are not allowable.

Only the following Modifications are covered:

- 1) Special adaptations to kitchen counters, sink space, cabinets, 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 person'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.

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 Iowa Administrative Code and a binding contract between the provider and the person. All contracts for home or vehicle modification shall be awarded through competitive bidding. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager.

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. The HVM has an annual limit published in Iowa Administrative Code which is subject to change on a yearly basis.

When the person has reached the upper limit, the case manager may assist the person to seek out other funding streams that may be available to assist them such as grants or other volunteer agencies that may assist.

Excluded services and costs. Services, activities, costs, and time that are not covered include modifications that are necessary or desirable without regard to the person'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, roof repair, or adding square footage to the residence, are excluded except as specifically included above. Repairs are also excluded. Repairs include any action that is intended to restore to a good or sound condition after decay or damage. Purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle are excluded.

The manufacturer recommended upkeep and routine maintenance of the modifications are included.

The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services are appropriately authorized in the person's person-centered service plan as needed. Where there is a potential for overlap, services must first be exhausted under Section 110 of the Rehabilitation Act of 1973. The first line of prevention of duplicative billing for similar types of services, such as family and community support service, is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as described in the person-centered service plan.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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

Remote/via Telehealth

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	Enrolled Home and Vehicle Modifications Provider
Agency	Area Agency on Aging

Provider Category	Provider Type Title
Agency	Community Action Agency
Agency	Supported Community Living Provider
Agency	Community Business

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home and Vehicle Modification

Provider Category:

Agency

Provider Type:

Enrolled Home and Vehicle Modifications Provider

Provider Qualifications

License (specify):

Certificate (specify):

Certified or Accredited enrolled HCBS providers under Iowa Administrative Code 441.

Other Standard (specify):

Provider that meets the requirements for home or vehicle modification provider that meets the requirements at Administrative Code 441 Chapters 77 and 78.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home and Vehicle Modification

Provider Category:

Agency

Provider Type:

Area Agency on Aging

Provider Qualifications

License (specify):

Certificate (specify):

08/15/2025

Other Standard (specify):

Area agency on aging designated in accordance with Iowa Code 231.

For this service, the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience, or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible for ensuring 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 5 years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home and Vehicle Modification

Provider Category:

Agency

Provider Type:

Community Action Agency

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

Community action agencies designated in Iowa Code section 216A.93 and governed by a board of directors in accordance with Iowa Code 216A.94.

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 for ensuring 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 5 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 Provider

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

Providers certified by the Department's Home and Community Based Services Quality Improvement Organization to provide Supported Community Living in accordance with Iowa Administrative Code 441 Chapter 77.

Other Standard (specify):

An enrolled HCBS waiver provider can subcontract the modifications to local qualified providers. The HCBS waiver provider acts in an administrative function for billing for the modification.

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

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

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Community Business

Provider Qualifications**License (specify):**

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):**

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

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

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

Service Type:

Other Service

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

Service Title:

Interim Medical Monitoring and Treatment (IMMT)

HCBS Taxonomy:**Category 1:**

11 Other Health and Therapeutic Services

Sub-Category 1:

11010 health monitoring

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Interim medical monitoring and treatment services (IMMT) are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. IMMT are for those whose complex medical needs require supervision and monitoring, when alternative care is unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. The case manager must identify the need for IMMT services after evaluating the person's living environment, family and natural supports, ability to perform activities of daily living, and health care needs.

The services must be needed:

- 1) To allow the person's usual caregivers to be employed,
- 2) During a search for employment by a usual caregiver,
- 3) To allow for academic or vocational training of a usual caregiver,
- 4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- 5) Due to the death of a usual caregiver.

Usual caregiver means an unpaid person or persons who reside with the member and are available on a 24- hour per-day basis to assume responsibility for the care of the member.

Interim medical monitoring and treatment services shall:

- 1) Provide experiences for each person's social, emotional, intellectual, and physical development;
- 2) Include comprehensive developmental care and any special services for a person with special needs; and
- 3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

- 4) Be in need as ordered by a physician.

Interim medical monitoring and treatment services may include supervision to and from a work setting, but not the cost of the transportation.

Home Health agencies enrolled to deliver IMMT services employ a variety of professionals, including RN, LPN, and Home Health Aides to deliver the IMMT services. The professional delivering the service is dependent on the needs of the person. The training or experience required must be determined by the person's usual caregivers and a licensed medical professional on the person's interdisciplinary team.

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager.

These services are limited to additional services not otherwise covered under the state plan, 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. A maximum of 48 15-minute units of service for a total of 12 hours are available per day. The rates for allowable provider types are published in the Iowa Administrative Code. The rates are subject to change on a yearly basis.

Limitations include:

- These services may be provided only in the person's home, in a registered group childcare home, in a registered family childcare home, in a licensed childcare center, or during transportation to and from school.
- Covered services do not include a complete nutritional regimen.
- The staff-to-person ratio shall not be greater than one (1) to six (6).

The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services are appropriately authorized in the person's person-centered service plan as needed. Where there is a potential for overlap, services must first be exhausted under Section 110 of the Rehabilitation Act of 1973. The first line of prevention of duplicative billing for similar types of services is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as described in the person-centered service plan.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Supported Community Living provider
Agency	Child Care Facility

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Interim Medical Monitoring and Treatment (IMMT)****Provider Category:**

Agency

Provider Type:

Home Health Agency

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

Home health agencies certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891), and, unless exempted under Iowa Administrative Code, have submitted a surety bond.

Other Standard (specify):

SStaff members providing interim medical monitoring and treatment services to persons shall meet all of the following requirements:

- (1) Be at least 18 years of age, and
- (2) Not be the spouse of the person or a parent or stepparent of the person if the person is aged 17 or under, and
- (3) Not be a usual caregiver of the person, and
- (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the person's service plan. The training or experience required must be determined by the person's usual caregivers and a licensed medical professional on the person's interdisciplinary team and must be documented in the person's service plan.

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

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

Frequency of Verification:

Every five years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Interim Medical Monitoring and Treatment (IMMT)****Provider Category:**

Agency

Provider Type:

Supported Community Living provider

Provider Qualifications**License (specify):**

Certificate (specify):

Providers certified by the Department's Home and Community Based Services Quality Improvement Organization to provide Supported Community Living in accordance with Iowa Administrative Code 441 Chapter 77.

Other Standard (specify):

Staff members providing interim medical monitoring and treatment services to persons shall meet all of the following requirements:

- (1) Be at least 18 years of age, and
- (2) Not be the spouse of the person or a parent or stepparent of the person if the person is aged 17 or under, and
- (3) Not be a usual caregiver of the person, and
- (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the person's service plan. The training or experience required must be determined by the person's usual caregivers and a licensed medical professional on the person's interdisciplinary team and must be documented in the person's service plan.

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

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

Frequency of Verification:

Every five years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Interim Medical Monitoring and Treatment (IMMT)

Provider Category:

Agency

Provider Type:

Child Care Facility

Provider Qualifications**License (specify):**

Childcare facilities that are defined as childcare centers or child development homes licensed and in good standing by the department in accordance with Iowa Administrative Code 441 Chapter 109 and 110.

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

Staff members providing interim medical monitoring and treatment services to persons shall meet all of the following requirements:

- (1) Be at least 18 years of age, and
- (2) Not be the spouse of the person or a parent or stepparent of the person if the person is aged 17 or under, and
- (3) Not be a usual caregiver of the person, and
- (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the person's service plan. The training or experience required must be determined by the person's usual caregivers and a licensed medical professional on the person's interdisciplinary team and must be documented in the person's service plan.

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

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Medical Day Care for Children

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04080 medical day care for children

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Medical Day Care for Children provides supervision and support of children 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

- 1.) medically necessary as verified in writing by the child's healthcare professional,
- 2.) documented in the child's person-centered service plan and 3.) allow the child's usual caregivers to be employed, engaged in academic or vocational training, or support the child due to the death or hospitalization of a usual caregiver.

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:

- 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 them.
- 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.
- A complex and unstable medical condition that requires constant and direct supervision.

- Needs exceeding the range of activities that a legally responsible person 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.

Medical Day Care for Children shall:

- 1) Provide experiences for each child's social, emotional, intellectual, and physical development;
- 2) Include comprehensive developmental care and any special services for a person with special needs; and
- 3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager.

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

A unit of service is 15 minutes. The rates for allowable provider types are published in the Iowa Administrative Code. The rates are subject to change on a yearly basis.

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 must be provided outside periods when the child is in school. "School" refers to brick and mortar school buildings where students attend classes in person during school hours set by the school district. When provided outside the person's home, the service 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 waiver services.

The services under this waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives to avoid institutionalization. The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services, including EPSDT, are appropriately authorized in the person's person-centered service plan as needed.

The first line of prevention of duplicative billing for similar types of services, such as attendant care, is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as ordered. The IoWANS system generates a review report to assist the case manager. The report identifies all services that are billed for a specific time period (ex. one month). The case manager can view the service billed to the person, the amount of the service billed, and the provider. The case manager can compare what is billed by the provider to what is ordered in the service plan.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Child Care Facility
Agency	Home Care Agency
Agency	Supported Community Living Providers certified under the BI or ID Waiver
Agency	HCBS Specialized Respite Provider

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*):

Home health agencies certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891), and, unless exempted under Iowa Administrative Code, have submitted a surety bond.

Other Standard (*specify*):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older and is not the spouse of the person served or the parent or stepparent of a person aged 17 or under. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider or employed to provide attendant care services through the consumer choices option.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The home care agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

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

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 during service 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Medical Day Care for Children

Provider Category:

Agency

Provider Type:

Child Care Facility

Provider Qualifications

License (specify):

Childcare facilities that are defined as childcare centers or child development homes licensed in accordance with Iowa Administrative Code 441.

Certificate (specify):

Other Standard (specify):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older and is not the spouse of the person served or the parent or stepparent of a person aged 17 or under. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider or employed to provide attendant care services through the consumer choices option.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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.

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

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 during service 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.

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):

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.

Other Standard (specify):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older and is not the spouse of the person served or the parent or stepparent of a person aged 17 or under. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider or employed to provide attendant care services through the consumer choices option.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who

receives home- and community-based services.

(4) 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.

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

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 during service 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.

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

08/15/2025

Community Living in accordance with Iowa Administrative Code 441.

Other Standard (*specify*):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older and is not the spouse of the person served or the parent or stepparent of a person aged 17 or under. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider or employed to provide attendant care services through the consumer choices option.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The home care agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

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

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 during service 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.

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:

HCBS Specialized Respite Provider

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

Certified to provide Respite by the Department's Home and Community Based Services Quality Oversight Unit as outlined in Iowa Administrative Code 441.

Other Standard (specify):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older and is not the spouse of the person served or the parent or stepparent of a person aged 17 or under. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider or employed to provide attendant care services through the consumer choices option.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The home care agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

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

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 during service 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

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

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

Frequency of Verification:

08/15/2025

Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System or Portable Locator System

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14010 personal emergency response system (PERS)

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 person.

A portable locator system is an electronic device that transmits a signal to a monitoring device. The portable locator system allows a person to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a person who is unable to request help or to activate a system independently. The person must be unable to access assistance in an emergency situation due to the person'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 person.
- 2) Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each person as applicable.

Provider staff are responsible for training persons 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 persons in understanding how to utilize the system.

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager.

These services are limited to additional services not otherwise covered under the state plan, 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 ongoing monthly units of service.

The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services are appropriately authorized in the person's person-centered service plan as needed. Where there is a potential for overlap, services must first be exhausted under Section 110 of the Rehabilitation Act of 1973. The first line of prevention of duplicative billing for similar types of services, such as family and community support service, is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as described in the person-centered service plan.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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

Remote/via Telehealth

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 Provider
Agency	Assisted Living Program

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System or Portable Locator System

Provider Category:

Agency

Provider Type:

Emergency Response System Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Emergency response system providers in accordance with Iowa Administrative Code 441. Chapters 77

For this service, the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience, or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible for ensuring 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 Dept. of Human services to The Department of Health and Human Services, Iowa Medicaid, Provider Services unit

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System or Portable Locator System

Provider Category:

Agency

Provider Type:

Assisted Living Program

Provider Qualifications

License (specify):

Certificate (specify):

Assisted Living programs certified by the Iowa Department of Inspections and Appeals and Licensing under Iowa Administrative Code 441 Chapter 69.

Other Standard (specify):

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

Positive Behavioral Support and Consultation

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Positive Behavioral Support and Consultation are services that consist of developing, implementing, and monitoring a person-centered, individually designed, proactive plan to address challenging behaviors and prevent potential crisis situations. A professional develops this plan to enhance a person's quality of life through the process of teaching or increasing positive behavior. When possible, the member leads the process to develop a positive behavioral support plan that is incorporated into their person-centered service plan (PCSP).

Positive Behavioral Support services include:

- Use of person-centered approaches that incorporate a comprehensive, functional behavior assessment of both positive and challenging behavior.
- Development of a positive behavior support plan to teach an alternative, positive behavior that will result in an increase in the person's quality of life and decrease of the challenging behavior.
- Identification of potential crisis triggers and development of strategies to prevent or mitigate crisis situations.
- Development of a positive behavior support plan, when required, to phase out the use of restrictive interventions approved for use on a temporary basis.
- Implementation of the plan(s) developed under this service, including ongoing training, consultation, and supervision of paid staff, formal supports and informal supports.
- Periodic reassessment and modification of the plan(s), but no less than quarterly.

Types of appropriate positive behavioral supports include but are not limited to clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

- Token economies reinforce desired behavior with a tangible reinforcement of the person's preference.
- Clinical redirection includes verbal redirection or talking to the person to redirect their attention away from the targeted behavior or physical redirection by leading or guiding the person to a different environment.
- Reinforcement may be verbal praise or receipt of a tangible object or preferred activity.

- Extinction occurs when reinforcement of a previously reinforced behavior is discontinued.
- Modeling occurs when the person learns from watching someone else perform the desired behavior.
- Over-learning occurs when the person continues to practice newly acquired skills past the level of skill mastery.

The positive behavioral support plan goal must be identified in the person's person-centered service plan or treatment plan.

The positive behavioral support programs developed must be developed using evidenced based practices and may not include any experimental approaches to behavioral support.

Positive behavioral support may occur in the person's home or community.

Providers delivering this service via the Telehealth service delivery option must demonstrate policies and procedures that include:

- HIPAA compliant platforms;
- Support given when a person's needs include accessibility, translation, or has limited auditory or visual capacities;
- Have a contingency plan for provision of services if technology fails;
- Professionals do not practice outside of their respective scope; and
- Assessment of persons and caregivers that identifies a person's ability to participate in and outlines any accommodations needed while using Telehealth.

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager

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

A unit of service is a 15-minute unit.

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

The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services are appropriately authorized in the person's person-centered service plan as needed. The first line of prevention of duplicative billing for similar types of services is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as described in the person-centered service plan.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospice Provider
Agency	Mental Health Service Provider
Agency	Community Mental Health Center
Agency	Home Health Agency
Agency	Supported Community Living Provider
Agency	Mental Health Professional
Agency	Agencies which are accredited by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Positive Behavioral Support and Consultation****Provider Category:**

Agency

Provider Type:

Hospice Provider

Provider Qualifications**License (specify):**

Agencies which are licensed as meeting the hospice standards and requirements set forth in Department of Inspections and Appeals and Licensing per Iowa Administrative Code 481 Chapter 53

Certificate (specify):

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

Other Standard (specify):

Positive Behavioral Supports providers shall be required to have experience with or training regarding the special needs of persons receiving HCBS supports. In addition, they must meet the following requirements:

- (1) Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified professional as defined in Iowa Administrative Code 441. Formal assessment of a person's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- (2) Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified professional as defined in Iowa Administrative Code 441 and who are employees of a qualified provider.

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

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

Frequency of Verification:

Every five years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Positive Behavioral Support and Consultation****Provider Category:**

Agency

Provider Type:

Mental Health Service Provider

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

Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in Iowa Administrative Code 441 Chapter 24

Positive Behavioral Support providers shall be required to have experience with or training regarding the special needs of persons receiving HCBS supports. In addition, they must meet the following requirements:

- (1) Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified professional as defined in Iowa Administrative Code 441. Formal assessment of a person's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry. Implementation of the plan and training and supervision of caregivers, including
- (2) family members, must be done by behavioral aides who have been trained by a qualified professional as defined in Iowa Administrative Code 441 and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Positive Behavioral Support and Consultation

Provider Category:

Agency

Provider Type:

Community Mental Health Center

Provider Qualifications

License (specify):

Certificate (specify):

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

Other Standard (specify):

comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority. Providers of Positive Behavioral Support and Consultation shall be required to have experience with or training to work with persons receiving HCBS supports. In addition, they must meet the following requirements:

- (1) Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified professional as defined in Iowa Administrative Code 441. Formal assessment of a person's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- (2) Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified professional as defined in Iowa Administrative Code 441 and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Positive Behavioral Support and Consultation

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Home health agencies certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891), and, unless exempted under Iowa Administrative Code, have submitted a surety bond.

Other Standard (*specify*):

Positive Behavioral Support providers shall be required to have experience with or training regarding the special needs of persons receiving HCBS supports. In addition, they must meet the following requirements:

- (1) Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified professional as defined in Iowa Administrative Code 441. Formal assessment of a person's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- (2) Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified professional as defined in Iowa Administrative Code 441 Chapter 24 and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Positive Behavioral Support and Consultation

Provider Category:

Agency

Provider Type:

Supported Community Living Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Providers enrolled to deliver SCL waiver services in accordance with Iowa Administrative Code 441 Chapter 77.

Other Standard (*specify*):

Positive Behavioral Support providers shall be required to have experience with or training regarding the special needs of persons receiving HCBS supports. In addition, they must meet the following requirements:

- (1) Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified professional as defined in Iowa Administrative Code 441. Formal assessment of a person's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- (2) Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified professional as defined in Iowa Administrative Code 441 and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Positive Behavioral Support and Consultation

Provider Category:

Agency

Provider Type:

Mental Health Professional

Provider Qualifications

License (*specify*):

Mental health professionals licensed pursuant to 645 Chapter 31, 240, or 280 or possessing an equivalent license in another state.

Certificate (*specify*):

Other Standard (*specify*):

Providers of Positive Behavioral Support and Consultation shall be required to have experience with or training to work with persons receiving HCBS supports. In addition, they must meet the following requirements:

- (1) Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified professional as defined in Iowa Administrative Code 441. Formal assessment of a person's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- (2) Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified professional as defined in Iowa Administrative Code 441 and who are employees of a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service**Service Type: Other Service****Service Name: Positive Behavioral Support and Consultation****Provider Category:**

Agency

Provider Type:

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

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

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

Positive Behavioral Support providers shall be required to have experience with or training regarding the special needs of persons receiving HCBS supports. In addition, they must meet the following requirements:

- (1) Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified professional as defined in Iowa Administrative Code 441. Formal assessment of a person's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- (2) Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified professional as defined in Iowa Administrative Code 441 and who are employees of a qualified provider.

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

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

Frequency of Verification:

Every five years

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

Skilled Attendant Care

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Service activities performed to help a person with self-care tasks which the person would typically do independently if able. This service may be provided in a private residence or in Assisted Living.

Skilled Attendant Care activities may include helping the person 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:

- 1) Tube feedings of person 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, and changing of Foley catheters when required.
- 5) Respiratory care, including inhalation therapy, 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 activities of daily living, reality orientation, reminiscing therapy, re-motivation, and behavior modification.
- 8) Colostomy care.
- 9) Care of out-of-control medical conditions, including brittle diabetes and comfort care of terminal conditions.
- 10) Postsurgical care.
- 11) Monitoring medications requiring close supervision due to 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 changes in vital signs to the nurse or therapist.

Skilled Attendant Care is not skilled nursing care but is provided by a lay person who has been trained to provide the specific service needed by the person. 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. A licensed nurse or therapist is responsible for overseeing the care of the waiver enrollee but is not the service provider. The cost of the supervision is provided under state plan funding and is not provided under the waiver.

Skilled Attendant Care is a separate and distinct service from Home Health and Nursing. Covered service activities must be essential to the health, safety, and welfare of the person.

Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

The person, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the provider who will provide Attendant Care services and will provide training and supervision to the Attendant Care provider. The person, parent, guardian, or attorney in fact under a durable power of attorney for health care shall also determine the components of Attendant Care services to be provided.

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager.

These services are limited to additional services not otherwise covered under the state plan, 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 billed in whole units. The upper limits for allowable provider types are published in the Iowa Administrative Code. The rates are subject to change on a yearly basis.

Skilled Attendant care may be provided to a recipient of in-home health related care services, but not at the same time. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present.

Excluded services and costs. Services, activities, costs, and time that are not covered include the following (not an exclusive list):

- (1) Any activity related to supervising a person. Only direct services are billable.
- (2) Any activity that the person is able to perform
- (3) Costs of food
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis, and treatment services.
- (5) Exercise that does not require skilled services
- (6) Parenting or childcare for or on behalf of the person
- (7) Reminders and cueing
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services
- (9) Transportation costs
- (10) Wait times for any activity

The person's case manager is responsible for oversight to avoid duplication of services and to assure state plan services are appropriately authorized in the person's person-centered service plan as needed. The first line of prevention of duplicative billing for similar types of services is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as ordered. The IoWANS system generates a review report to assist the case manager. The report identifies all services that are billed for a specific time period (ex. one month). The case manager can view the service billed to the person, the amount of the service billed, and the provider. The case manager can compare what is billed by the provider to what is ordered in the service plan.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Community Living provider
Agency	Assisted Living Program
Agency	Home Health Agency
Agency	Community Action Agency
Agency	Community Business
Agency	Home Care Provider
Agency	Adult Day Care Provider
Agency	Area Agency on Aging

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled Attendant Care

Provider Category:

Agency

Provider Type:

Supported Community Living provider

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 in accordance with Iowa Administrative Code 441.

Other Standard (specify):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

For Skilled Attendant Care, the service activities may include helping the person with skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. 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 service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served.

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: Skilled Attendant Care

Provider Category:

Agency

Provider Type:

Assisted Living Program

Provider Qualifications

License (specify):

Certificate (specify):

Assisted Living programs certified by the Iowa Department of Inspections and Appeals under Iowa Administrative Code 481.

Other Standard (specify):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

For Skilled Attendant Care, the service activities may include helping the person with skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. 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 service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served.

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: Skilled Attendant Care**

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

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

For Skilled Attendant Care, the service activities may include helping the person with skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. 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 service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served.

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

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Skilled Attendant Care**

Provider Category:**Provider Type:****Provider Qualifications**

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

Community action agencies designated in Iowa Code section 216A.93 and governed by a board of directors in accordance with Iowa Code 216A.94. Community action agencies:

- (1) Plan and implement strategies to alleviate the conditions of poverty and encourage self-sufficiency for citizens in its service area and in Iowa.
- (2) Obtain and administer assistance from available sources on a common or cooperative basis, in an attempt to provide additional opportunities to low-income persons.
- (3) Establish effective procedures by which the concerned low-income persons and area residents may influence the community action programs affecting them by providing for methods of participation in the implementation of the community action programs and by providing technical support to assist persons to secure assistance available from public and private sources.
- (4) Encourage and support self-help, volunteer, business, labor, and other groups, and organizations to assist public officials and agencies in supporting a community action program.

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 for ensuring that the contractor is qualified and reliable. Case managers are responsible for monitoring service provision to ensure services are provided in a safe and effective manner.

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

For Skilled Attendant Care, the service activities may include helping the person with skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. 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 service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served.

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: Skilled Attendant Care****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 must submit verification of current liability and workers' compensation coverage.

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

For Skilled Attendant Care, the service activities may include helping the person with skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. 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 service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served

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: Skilled Attendant Care****Provider Category:**

Agency

Provider Type:

Home Care Provider

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

Home care providers that have a contract with the HHS or have written certification from the HHS stating they meet the home care standards and requirements set forth in Iowa Administrative Code 641.

Other Standard (specify):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

For Skilled Attendant Care, the service activities may include helping the person with skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. 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 service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served.

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: Skilled Attendant Care

Provider Category:

Agency

Provider Type:

Adult Day Care Provider

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

Adult Day Care Providers certified by the Iowa Department of Inspections and Appeals under Iowa Administrative Code 481.

Other Standard (specify):

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

For Skilled Attendant Care, the service activities may include helping the person with skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. 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 service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served.

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: Skilled Attendant Care

Provider Category:

Agency

Provider Type:

Area Agency on Aging

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers subcontracting with the Area Agencies on Aging or with letters of approval from the Area Agencies on Aging that the organization is qualified to provide skilled attendant care.

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 for ensuring that the contractor is qualified and reliable. Case managers are responsible for monitoring service provision to ensure services are provided in a safe and

effective manner.

Providers must:

- (1) Ensure services are rendered by a person who is 18 years of age or older. People who are 16 or 17 years old may provide services if employed and supervised by an enrolled HCBS provider.
- (2) Be qualified by training or experience to carry out the person's service plan pursuant to the department-approved service planning process.
- (3) Not be the recipient of Respite services paid through home- and community-based services on behalf of a person who receives home- and community-based services.
- (4) 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. The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

For Skilled Attendant Care, the service activities may include helping the person with skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. 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 service activities shall not include parenting or childcare for or on behalf of the person or on behalf of the provider.

Providers delivering services are required to have each of their staff involved in direct service complete training commensurate with the diagnoses and needs of the persons served

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:

Supported Community Living

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02011 group living, residential habilitation

Category 2:

Sub-Category 2:

02 Round-the-Clock Services

02023 shared living, other

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

02 Round-the-Clock Services

02031 in-home residential habilitation

Category 4:**Sub-Category 4:****Service Definition (Scope):**

Supported Community Living (SCL) services are delivered by the provider within the person's home and community, according to the person's individualized need as identified in the person-centered service plan (PCSP). Available components of SCL are:

- Personal and home skills training services: Activities that assist a person to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.
- Person advocacy services: The act or process of representing the person's rights and interests in order to realize the rights to which the person is entitled and to remove barriers to meeting the person's needs.
- Community skills training services: Activities that assist a person in developing or maintaining skills, allowing better participation in the community.
- Personal and environmental support services: 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.
- Transportation: 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.
- Treatment services: Activities designed to assist the person in maintaining or improving physiological, emotional, and behavioral functioning and prevent conditions that would present barriers to functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.
 - o Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the human body's normal functioning. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.
 - o Psychotherapeutic treatment means activities provided to assist a person in identifying or modifying beliefs, emotions, attitudes, or behaviors to maintain or improve the person's functioning in response to the physical, emotional, and social environment.

SCL shall focus on the following areas as they are applicable to persons being served:

- Personal management skills training services assist a person in maintaining or developing skills necessary to sustain oneself in the physical environment. They are essential to the management of one's business and property. Including self-advocacy skills. Examples of personal management skills are maintaining a household budget, planning and preparing nutritional meals, using community resources such as public transportation, libraries, etc., and selecting foods at the grocery store.
- Health, safety, and wellness training services are those activities that assist a person to maintain or develop skills necessary to support their health (e.g., taking medications), safety (e.g., locking doors, identifying trusted contacts when assistance is needed) and wellness (e.g., exercising and other activities to support physical and mental well-being).
- Socialization skills training services are those activities that assist a person in developing or maintaining skills that include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.
- Communication skills training services assist a person in developing or maintaining skills, including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

Providers delivering SCL via the Telehealth service delivery option must demonstrate policies and procedures that include:

- HIPAA-compliant platforms;
- Support given when a person's needs include accessibility, translation, or has limited auditory or visual capacities;
- Have a contingency plan for the provision of services if technology fails;
- Professionals do not practice outside of their respective scope; and
- Assessment of persons and caregivers that identifies a person's ability to participate in and outlines any accommodations needed while using Telehealth.

SCL is available through two alternate delivery models, Remote Support SCL Service Delivery Model and Host Home SCL Service Delivery Model.

The PCSP will address how the person's needs are met. Services must be authorized in the PCSP and monitored by the case

manager (CM).

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 a person'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 person's assessed needs.
- Is provided within the scope of the service being delivered, and
- Is provided as specified in the person's PCSP.

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, locations should have appropriate, stable, and redundant connections. This should include but is not limited to, backup generators or backup batteries and multiple internet service connections.

Remote supports may be used with either paid or unpaid backup support as specified in the person's PCSP. 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 person, friend, or other person who the person chooses. The person-centered PCSP will reflect how the remote supports are used to meet the goals for independent living and assessed needs, including health, safety, and welfare.

Remote Support Service Requirements

- An assessment must be performed by the SCL remote support provider with input from the person and their Interdisciplinary Team (IDT) assessing the person's ability to be supported safely through remote support. Through an assessment by the remote support provider with input from the person and their IDT, the location of the devices or monitors will be determined to best meet the person's needs.

Informed Consent

- Informed consent for the delivery of Remote Support SCL by the person using the service, their guardian and other persons and their guardians residing in the home must be obtained and clearly state the parameters for the remote support service.
- Each person, guardian, and IDT must know the operating parameters' benefits, risks, and limitations.
- Informed consent documents must be acknowledged in writing, signed, and dated by the person, guardian, CM, and provider agency representative, as appropriate. A copy of the consent shall be maintained by the CM and the guardian (if applicable) and placed in the home file.
- If the person desires to withdraw consent, they or their guardian must 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 persons, 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 person's privacy, including when the person is in settings typically used by the public, and when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares.
- Remote Support Professionals must only use cameras in bedrooms or bathrooms when the IDT has identified a specific support need in the PCSP and the person, and their legal representative if applicable, have given informed consent.
- The agency service provider responsible for responding to a person'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 Iowa Administrative Code.

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 to no more than (2) persons 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.

The participant's family home is not included within the definition of Host Home, and the parent or legally responsible person is not included in the definition of Host.

Host Home is an available delivery option through the SCL service to meet a person'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 person's assessed needs.
- Is provided within the scope of the service being delivered.
- Is provided as specified in the person's PCSP.

Service Requirements Assessment

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

Informed Consent

- Informed consent must be obtained for the delivery of SCL in the host home by the host home provider, the person using the service, and their guardian.
- Each person, 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 person, guardian, CM, and provider agency representative, as appropriate. A copy of the consent shall be maintained by the CM and the guardian (if applicable) and in the provider agency file.
- If the person desires to withdraw consent, sever the residential agreement, and transfer from the Host Home to a provider-owned and controlled SCL setting, the person, their guardian, or the Host must notify the SCL provider agency, and the person'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 providers must respect and always maintain the person's privacy, including when the person is in settings typically used by the public and when scheduled or intermittent/as-needed support includes responding to a person's health, safety, and other support needs for personal care.

For additional details on Remote Support, Telehealth and the Host Home Model see Main Optional B.

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

Supported community living services shall be available at a daily rate to members for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

A unit of service is:

- (1) One full calendar day when a member receives in person or remote staff supervision and support for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision or
- (2) 15-minute unit when the criteria for the daily rate is not met.

The maximum number of units available per member is as follows:

- (1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.
- (2) 11,315 15-minute units per state fiscal year except a leap year, when 11,346 15-minute units are available.

Additional service parameters include:

- 1) Supported Community Living services are intended to provide for the daily living needs of the person and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.
- 2) In-person contact is not required as a prerequisite for payment.

3) When SCL is 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.

4) When SCL is delivered in a Host Home, providers may not bill for direct support delivered in the Host Home when the person is absent from the home and is not receiving SCL or for which there is no supporting documentation of service delivery.

Services shall not be simultaneously reimbursed with other residential services, waiver-funded Respite, state plan or waiver-funded Nursing, or state plan or waiver-funded Home Health Aide services. The first line of prevention of duplicative billing for similar types of services is the person's case manager. The case manager is responsible for the authorization and monitoring of services in a person's PCSP. If the case manager authorizes similar services, they are responsible for ensuring that the services are delivered as ordered. The IoWANS system generates a review report to assist the case manager. The report identifies all services that are billed for a specific time period (ex. one month). The case manager can view the service billed to the person, the amount of the service billed, and the provider. The case manager can compare what is billed by the provider to what is ordered in the PCSP.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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, but consistent with waiver objectives of avoiding institutionalization.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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 Providers
Agency	Fost 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 Providers

Provider Qualifications

License (specify):

Providers of services meeting the definition of foster care shall also be licensed by the department according to applicable Iowa Administrative Code 441 chapters 108, 112, 114, 115, and 116.

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

Providers must meet the requirements and standards in Iowa Administrative Code 441 Chapter 77.

Agencies meeting the criteria as an SCL provider under 441-77 that seeks certification as an intensive residential service provider shall meet the following criteria at initial application and annually thereafter.

A certified intensive residential service provider shall:

- (1) Be enrolled as an intellectual disability waiver supported community living provider in good standing with the Iowa Medicaid.
- (2) Provide staffing 24 hours a day, 7 days a week, 365 days a year.
- (3) Maintain a minimum staffing ratio of one staff to every two residents. Staffing ratios shall be responsive to the needs of the individuals served.
- (4) Ensure that all staff members have the following minimum qualifications:
 1. One year of experience working with individuals with a mental illness or multi-occurring conditions.
 2. A high school diploma or equivalent.
- (5) Ensure that within the first year of employment, staff members complete 48 hours of training in mental health and multi-occurring conditions. During each consecutive year of employment, staff members shall complete 24 hours of training in mental health and multi-occurring conditions. Staff training shall include, but is not limited to the following:
 1. Applied behavioral analysis.
 2. Autism spectrum disorders, diagnoses, symptomology and treatment.
 3. Brain injury diagnoses, symptomology and treatment.
 4. Crisis management and de-escalation and mental health diagnoses, symptomology and treatment.
 5. Motivational interviewing.
 6. Psychiatric medications.
 7. Substance use disorders and treatment.
 8. Other diagnoses or conditions present in the population served.
- (6) Provide coordination with the individual's clinical mental health and physical health treatment, and other services and supports.
- (7) Provide clinical oversight by a mental health professional. The mental health professional shall review and consult on all behavioral health services provided to the individual, and any other plans developed for the individual, including but not limited to service plans, behavior intervention plans, crisis intervention plans, emergency plans, cognitive rehabilitation plans, or physical rehabilitation plans.
- (8) Have a written cooperative agreement with an outpatient mental health provider and ensure that individuals have timely access to outpatient mental health services,
- (9) Be licensed as a substance abuse treatment program pursuant to Iowa Code chapter 125 or have a written cooperative agreement with and timely access to licensed substance abuse treatment services for those individuals with a demonstrated need.
- (10) Accept and serve eligible individuals who are court-ordered to intensive residential services.
- (11) Provide services to eligible individuals on a no reject, no eject basis.
- (12) If funded through HCBS and not licensed as a residential care facility, serve no more than five individuals at a site with approval from the Bureau of Long-Term Services and Support.
- (13) Be located in a neighborhood setting to maximize community integration and natural supports.
- (14) Demonstrate specialization in serving individuals with serious and persistent mental illness or multi-occurring conditions and serve individuals with similar conditions in the same sit.

The following are requirements of a remote supports system design when utilized to replace in-person direct support service delivery:

1. 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 person's home in the event of electrical outages.
2. 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 how remote and backup staff will respond to each. Examples include:
 - a. Fire, medical crises, strangers in the home, violence between individuals and any other situation that appears to threaten

the health or welfare of the person.

- b. 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.
- c. 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.
3. 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 person'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 person's home, including any previously identified paid or unpaid backup support responder.
4. 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.
5. 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 persons in each living site, including emergency situations when the person may not be able to use the telephone.
6. The remote supports system may allow the monitoring base staff to have visual (video) oversight of areas in person's residential living sites as deemed necessary by the IDT to meet the person's needs based on informed consent of the person and/ or their legal representative.
7. A remote supports monitoring base may not be located in the home of the person receiving remote support.
8. 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 person's service plan, and state entities as necessary for the oversight of service delivery.
9. Persons receiving supports must be made aware of the operating hours of the equipment.
10. For situations involving remote supports of persons needing 24-hour support, if a person 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 person'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 persons receiving supports and shall receive the following training at a minimum:

- a. Dependent adult abuse reporting
- b. Incident Reporting
- c. Rights
- d. Provider's Remote Support Policies and Procedures
- e. Individual 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 persons receiving supports and shall receive the following training at a minimum:

- a. Dependent adult abuse reporting
- b. Incident Reporting
- c. Rights
- d. Individual remote support protocols/ person-centered service plans
- e. Provider's Remote Support Policies and Procedures
- f. Meet the Supported Community Living staff qualifications in Iowa Administrative Code 441. Host Home providers delivering SCL services must:
 - a. Meet the staff qualifications in Iowa Administrative Code 441.
 - b. Receive pre-service training:
 - c. The philosophy of HCBS, including HCBS settings requirements and expectations
 - d. The organization's mission, policies, and procedures
 - e. The organization's policy related to identifying and reporting abuse.
 - f. 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)
 - g. Rights including outcomes for rights and dignity as applicable.
 - h. Restrictive interventions (restraints, rights restrictions, and behavioral intervention)
 - i. Individual support needs (prior to serving the person and as updated)
 - j. Specific behavior support or de-escalation curriculum such as Mandt, Safety-Care, PBIS, CPI, or other
 - k. Confidentiality and safeguarding information

- l. The organization's policy related to medication.
- m. An approved Medication Manager training for any contractors that are administering controlled substances.
- n. Identifying and reporting incidents
- o. Service documentation
- p. Training commensurate to diagnosis and needs of the participants served

For additional requirements for providers delivering SCL through the Host Home Model see Main Option B.

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:

Fost 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 Iowa Administrative Code 441. Chapters 112 and 113

Certificate (specify):

Other Standard (specify):

Providers must meet the requirements and standards in Iowa Administrative Code 441 Chapter 77.

Agencies meeting the criteria as an SCL provider under 441-77 that seeks certification as an intensive residential service provider shall meet the following criteria at initial application and annually thereafter.

A certified intensive residential service provider shall:

- (1) Be enrolled as an intellectual disability waiver supported community living provider in good standing with the Iowa Medicaid.
- (2) Provide staffing 24 hours a day, 7 days a week, 365 days a year.
- (3) Maintain a minimum staffing ratio of one staff to every two residents. Staffing ratios shall be responsive to the needs of the individuals served.
- (4) Ensure that all staff members have the following minimum qualifications:
 1. One year of experience working with individuals with a mental illness or multi-occurring conditions.
 2. A high school diploma or equivalent.
- (5) Ensure that within the first year of employment, staff members complete 48 hours of training in mental health and multi-occurring conditions. During each consecutive year of employment, staff members shall complete 24 hours of training in mental health and multi-occurring conditions. Staff training shall include, but is not limited to the following:
 1. Applied behavioral analysis.
 2. Autism spectrum disorders, diagnoses, symptomology and treatment.
 3. Brain injury diagnoses, symptomology and treatment.
 4. Crisis management and de-escalation and mental health diagnoses, symptomology and treatment.
 5. Motivational interviewing.

6. Psychiatric medications.
7. Substance use disorders and treatment.
8. Other diagnoses or conditions present in the population served.
- (6) Provide coordination with the individual's clinical mental health and physical health treatment, and other services and supports.
- (7) Provide clinical oversight by a mental health professional. The mental health professional shall review and consult on all behavioral health services provided to the individual, and any other plans developed for the individual, including but not limited to service plans, behavior intervention plans, crisis intervention plans, emergency plans, cognitive rehabilitation plans, or physical rehabilitation plans.
- (8) Have a written cooperative agreement with an outpatient mental health provider and ensure that individuals have timely access to outpatient mental health services,
- (9) Be licensed as a substance abuse treatment program pursuant to Iowa Code chapter 125 or have a written cooperative agreement with and timely access to licensed substance abuse treatment services for those individuals with a demonstrated need.
- (10) Accept and serve eligible individuals who are court-ordered to intensive residential services.
- (11) Provide services to eligible individuals on a no reject, no eject basis.
- (12) If funded through HCBS and not licensed as a residential care facility, serve no more than five individuals at a site with approval from the Bureau of Long-Term Services and Support.
- (13) Be located in a neighborhood setting to maximize community integration and natural supports.
- (14) Demonstrate specialization in serving individuals with serious and persistent mental illness or multi-occurring conditions and serve individuals with similar conditions in the same sit.

The following are requirements of a remote supports system design when utilized to replace in-person direct support service delivery:

1. 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 person's home in the event of electrical outages.
2. 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 how remote and backup staff will respond to each. Examples include:
 - a. Fire, medical crises, strangers in the home, violence between individuals and any other situation that appears to threaten the health or welfare of the person.
 - b. 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.
 - c. 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.
3. 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 person'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 person's home, including any previously identified paid or unpaid backup support responder.
4. 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.
5. 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 persons in each living site, including emergency situations when the person may not be able to use the telephone.
6. The remote supports system may allow the monitoring base staff to have visual (video) oversight of areas in person's residential living sites as deemed necessary by the IDT to meet the person's needs based on informed consent of the person and/ or their legal representative.
7. A remote supports monitoring base may not be located in the home of the person receiving remote support.
8. 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 person's service plan, and state entities as necessary for the oversight of service delivery.
9. Persons receiving supports must be made aware of the operating hours of the equipment.
10. For situations involving remote supports of persons needing 24-hour support, if a person 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 person'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 persons receiving supports and shall receive the following training at a minimum:

- a. Dependent adult abuse reporting
- b. Incident Reporting
- c. Rights
- d. Provider's Remote Support Policies and Procedures
- e. Individual 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 persons receiving supports and shall receive the following training at a minimum:

- a. Dependent adult abuse reporting
- b. Incident Reporting
- c. Rights
- d. Individual remote support protocols/ person-centered service plans
- e. Provider's Remote Support Policies and Procedures
- f. Meet the Supported Community Living staff qualifications in Iowa Administrative Code 441. Host Home providers delivering SCL services must:
 - a. Meet the staff qualifications in Iowa Administrative Code 441.
 - b. Receive pre-service training:
 - c. The philosophy of HCBS, including HCBS settings requirements and expectations
 - d. The organization's mission, policies, and procedures
 - e. The organization's policy related to identifying and reporting abuse.
 - f. 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)
 - g. Rights including outcomes for rights and dignity as applicable.
 - h. Restrictive interventions (restraints, rights restrictions, and behavioral intervention)
 - i. Individual support needs (prior to serving the person and as updated)
 - j. Specific behavior support or de-escalation curriculum such as Mandt, Safety-Care, PBIS, CPI, or other
 - k. Confidentiality and safeguarding information
 - l. The organization's policy related to medication.
 - m. An approved Medication Manager training for any contractors that are administering controlled substances.
 - n. Identifying and reporting incidents
 - o. Service documentation
 - p. Training commensurate to diagnosis and needs of the participants served

For additional requirements for providers delivering SCL through the Host Home Model see Main Option B.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five year

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supported Community Living

Provider Category:

Agency

Provider Type:

Certified Supported Community Living Providers

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

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

Other Standard (specify):

Providers must meet the requirements and standards in Iowa Administrative Code 441 Chapter 77.

Agencies meeting the criteria as an SCL provider under 441-77 that seeks certification as an intensive residential service provider shall meet the following criteria at initial application and annually thereafter.

A certified intensive residential service provider shall:

- (1) Be enrolled as a waiver supported community living provider in good standing with the Iowa Medicaid.
- (2) Provide staffing 24 hours a day, 7 days a week, 365 days a year.
- (3) Maintain a minimum staffing ratio of one staff to every two residents. Staffing ratios shall be responsive to the needs of the individuals served.
- (4) Ensure that all staff members have the following minimum qualifications:
 1. One year of experience working with individuals with a mental illness or multi-occurring conditions.
 2. A high school diploma or equivalent.
- (5) Ensure that within the first year of employment, staff members complete 48 hours of training in mental health and multi-occurring conditions. During each consecutive year of employment, staff members shall complete 24 hours of training in mental health and multi-occurring conditions. Staff training shall include, but is not limited to the following:
 1. Applied behavioral analysis.
 2. Autism spectrum disorders, diagnoses, symptomology and treatment.
 3. Brain injury diagnoses, symptomology and treatment.
 4. Crisis management and de-escalation and mental health diagnoses, symptomology and treatment.
 5. Motivational interviewing.
 6. Psychiatric medications.
 7. Substance use disorders and treatment.
 8. Other diagnoses or conditions present in the population served.
- (6) Provide coordination with the individual's clinical mental health and physical health treatment, and other services and supports.
- (7) Provide clinical oversight by a mental health professional. The mental health professional shall review and consult on all behavioral health services provided to the individual, and any other plans developed for the individual, including but not limited to service plans, behavior intervention plans, crisis intervention plans, emergency plans, cognitive rehabilitation plans, or physical rehabilitation plans.
- (8) Have a written cooperative agreement with an outpatient mental health provider and ensure that individuals have timely access to outpatient mental health services,
- (9) Be licensed as a substance abuse treatment program pursuant to Iowa Code chapter 125 or have a written cooperative agreement with and timely access to licensed substance abuse treatment services for those individuals with a demonstrated need.
- (10) Accept and serve eligible individuals who are court-ordered to intensive residential services.
- (11) Provide services to eligible individuals on a no reject, no eject basis.
- (12) If funded through HCBS and not licensed as a residential care facility, serve no more than five individuals at a site with approval from the Bureau of Long-Term Services and Support.
- (13) Be located in a neighborhood setting to maximize community integration and natural supports.
- (14) Demonstrate specialization in serving individuals with serious and persistent mental illness or multi-occurring conditions and serve individuals with similar conditions in the same sit.

The following are requirements of a remote supports system design when utilized to replace in-person direct support service delivery:

1. 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 person's home in the event of electrical outages.
2. 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 how remote and backup staff will respond to each. Examples include:
 - a. Fire, medical crises, strangers in the home, violence between individuals and any other situation that appears to threaten the health or welfare of the person.

- b. 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.
- c. 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.
3. 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 person'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 person's home, including any previously identified paid or unpaid backup support responder.
4. 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.
5. 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 persons in each living site, including emergency situations when the person may not be able to use the telephone.
6. The remote supports system may allow the monitoring base staff to have visual (video) oversight of areas in person's residential living sites as deemed necessary by the IDT to meet the person's needs based on informed consent of the person and/ or their legal representative.
7. A remote supports monitoring base may not be located in the home of the person receiving remote support.
8. 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 person's service plan, and state entities as necessary for the oversight of service delivery.
9. Persons receiving supports must be made aware of the operating hours of the equipment.
10. For situations involving remote supports of persons needing 24-hour support, if a person 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 person'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 persons receiving supports and shall receive the following training at a minimum:

- a. Dependent adult abuse reporting
- b. Incident Reporting
- c. Rights
- d. Provider's Remote Support Policies and Procedures
- e. Individual 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 persons receiving supports and shall receive the following training at a minimum:

- a. Dependent adult abuse reporting
- b. Incident Reporting
- c. Rights
- d. Individual remote support protocols/ person-centered service plans
- e. Provider's Remote Support Policies and Procedures
- f. Meet the Supported Community Living staff qualifications in Iowa Administrative Code 441. Host Home providers delivering SCL services must:
 - a. Meet the staff qualifications in Iowa Administrative Code 441.
 - b. Receive pre-service training:
 - c. The philosophy of HCBS, including HCBS settings requirements and expectations
 - d. The organization's mission, policies, and procedures
 - e. The organization's policy related to identifying and reporting abuse.
 - f. 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)
 - g. Rights including outcomes for rights and dignity as applicable.
 - h. Restrictive interventions (restraints, rights restrictions, and behavioral intervention)
 - i. Individual support needs (prior to serving the person and as updated)
 - j. Specific behavior support or de-escalation curriculum such as Mandt, Safety-Care, PBIS, CPI, or other
 - k. Confidentiality and safeguarding information

- l. The organization's policy related to medication.
- m. An approved Medication Manager training for any contractors that are administering controlled substances.
- n. Identifying and reporting incidents
- o. Service documentation
- p. Training commensurate to diagnosis and needs of the participants served

For additional requirements for providers delivering SCL through the Host Home Model see Main Option B.

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:

15 Non-Medical Transportation

Sub-Category 1:

15010 non-medical transportation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Transportation services may be provided for persons to conduct business errands, essential shopping, travel to and from work or day programs, and to reduce social isolation. Whenever possible, natural supports, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.

This service does not include transportation to Medicaid covered medical services; this service is offered in addition to medical transportation required under 42 CFR Section 431.53 and transportation services the State Plan defined at 42 CCR Section 440.170(a) and does not replace them.

The case manager responsible for person-centered service plan development, and authorization will identify the availability of alternative sources of transportation in the person's person-centered service plan. As part of the annual person-centered planning process the person's interdisciplinary team identifies the transportation needs of the person and identifies paid or unpaid resources to meet the need.

The person-centered service plan will address how the person's needs are met. Services must be authorized in the person-centered service plan and monitored by the case manager.

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 mile or one way trip. The upper limit for allowable provider types is published in the Iowa Administrative Code. Rates are subject to change on a yearly basis.

Transportation may not be reimbursed simultaneously with any other transportation services with the exception of an escort during transportation. Additionally, it may not be duplicative of any transportation service provided under the State Plan (i.e. non-emergency medical transportation (NEMT) Transportation shall not be reimbursed simultaneously with Supported Community Living services when the SCL rate paid to the provider include the cost of the person's transportation.

The first line of prevention of duplicative billing for similar type services is the person's case manager. The case manager is responsible for authorizing and monitoring of services in a person's service plan. If the case manager authorized similar services, they are responsible for ensure that the services are delivered as described in the person-centered service plan.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules (WoAR) option. WoARs can be requested but cannot be requested for Federal requirements or state law. Persons needing additional services to ensure health, safety, or other issues can request WoARs. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding WoAR 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

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Area Agency on Aging
Agency	Non-Emergency Medical Transportation Provider contracted with the NEMT Broker
Agency	Regional Transit Authority
Agency	Community Action Agency
Agency	Nursing Facilities
Agency	Supported Community Living 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:

Area Agency on Aging

Provider Qualifications**License (specify):**

Enrolled providers must ensure all necessary licenses and insurance coverage required by federal, state, and local laws and regulations including a valid driver's license are in place.

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

Area agencies on aging designated in accordance with Iowa Code 231 or 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.

AAA shall maintain a file of all current contracts with service providing agencies or organizations. These files shall be made available for monitoring and assessment by the department.

Contracts with for-profit organizations. A AAA must require prior approval from the department of any proposed service contracts with for provider organizations under an area plan.

(1) A separate approval request using the request form provided by the department shall be filed for each contract between the AAA and a provider for a service that is proposed to be delivered by a for-profit organization.

- a. The request for approval shall be submitted to the department a least 30 days prior to the signing of the contract,
- b. All applicants to provide services for which the contract is proposed shall be listed on the request form.

(2) The department may approve the contracts only if the AAA demonstrated s that the for-profit organization can provide services that are consistent with the goal of the AAA as stated in the area plan.

For this service, the department does not have specific standards for the subcontracts or providers regarding training, age limitation, experience or education beyond those implemented by the contracting agency. Contracting agencies are responsible for ensuring 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:

Non-Emergency Medical Transporation Provider contracted with the NEMT Broker

08/15/2025

Provider Qualifications**License (specify):**

Enrolled providers must ensure all necessary licenses and insurance coverage required by federal, state, and local laws and regulations including a valid driver's license are in place.

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

Provider in good standing with and participating in Iowa Medicaid's NEMT program under Iowa Administrative Code 78.13

For this service, the department does not have specific standards for the subcontracts or providers regarding training, age limitation, experience or education beyond those implemented by the contracting agency. The NEMT broker(s) are responsible for ensuring 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:

Regional Transit Authority

Provider Qualifications**License (specify):**

Enrolled providers must ensure all necessary licenses and insurance coverage required by federal, state, and local laws and regulations including a valid driver's license are in place.

Certificate (specify):

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

Other Standard (specify):

As designated by the Iowa Department of Transportation in Iowa Code 28M.1. "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.

Regional Transit Agencies as recognized by the Iowa Department of Transportation. These agencies must:

- (1) Comply with the Code of Federal Regulations pertaining to public transit;
- (2) Demonstrate that vehicles used comply with public transit regulations surrounding acceptable mileage thresholds and maintenance schedule;
- (3) Ensure that drivers must possess a commercial driver's license;

(4) Ensure that employees pass routine drug and alcohol screening.

All individuals proving transportation must possess the following qualifications:

- (1) Hold a commercial driver's license
- (2) Routinely pass drug and alcohol testing
- (3) Undergo training consistent with the policies of the Office of Public Transit.

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

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

Frequency of Verification:

Every five years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications**License (specify):**

Enrolled providers must ensure all necessary licenses and insurance coverage required by federal, state, and local laws, regulations, including a valid driver's licenses are in place.

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

Community action agencies as designated in Iowa Code section 216A.93 and governed by the board of directors in accordance with Iowa Code 216A.94.

For this service, the department does not have specific standards for the subcontracts or providers regarding training, age limitation, experience or education beyond those implemented by the contracting agency. The contracting agencies are responsible for ensuring 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:

Nursing Facilities

Provider Qualifications**License (specify):**

Licensed pursuant to Iowa Code Chapter 135C and qualifying for Medicaid enrollment as described in administrative code 441.

Enrolled providers must ensure all necessary licenses and insurance coverage required by federal, state, and local laws, regulations, including a valid driver's licenses are in place.

Certificate (specify):

Facility means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to Separatemtn

Other Standard (specify):

For this service, the department does not have specific standards for the subcontracts or providers regarding training, age limitation, experience or education beyond those implemented by the contracting agency. 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:

Supported Community Living Provider

Provider Qualifications**License (specify):**

Enrolled providers must ensure all necessary licenses and insurance coverage required by federal, state, and local laws and regulations including a valid driver's license are in place.

Certificate (specify):

Providers certified by the HCBS QIO to provide Supported Community Living pursuant to Iowa Administrative Code 441 Chapter 77.

Other Standard (specify):

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. Providers 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: 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 section 1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under section 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.*

As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management). *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

FFS

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

All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned.

MCO

MCO community-based case managers provide case management services to all members receiving HCBS. MCOs ensure ease of access and responsiveness for each member to their community-based case manager during regular business hours and, at a minimum, the community-based case manager contacts members at least monthly, either in person or by phone, with an interval of at least fourteen calendar days between contacts.

MCO community-based case managers provide case management services to all members receiving HCBS. MCOs ensure ease of access and responsiveness for each member to their community-based case manager during regular business hours and, at a minimum, the community-based case manager or integrated health home care coordinator contacts members at least monthly, either in person or by phone, with an interval of at least fourteen calendar days between contacts.

All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned. MCOs are contractually required to ensure the delivery of services in a conflict free manner consistent with Balancing Incentive Program requirements. HHS approves and monitors all MCO policies and procedures to ensure compliance.

Payment will be approved for targeted case management services for members of the following populations who are not enrolled in an IA Health Link Managed Care Organization (MCO), not eligible for MCO enrollment

Medicaid members who are 18 years of age or over and have a primary diagnosis of:

- Intellectual disability, or
- Developmental disabilities, or
- Chronic mental illness.

Payment will be approved for Waiver Case Management and care coordination for BI Waiver members who are not enrolled in an IA Health Link Managed Care Organization

(MCO) or who are not eligible for MCO enrollment and are not eligible for Targeted Case Management.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Supported Employment
Supported Community Living

1. Will any in-person visits be required?

Yes.

No.

2. By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.

The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Explain:

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.

The model requires informed consent by member and/or legal representative, as well as clear definitions within the person-centered service plan. The 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.

How the telehealth service delivery will facilitate community integration. *Explain:*

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

How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual. *Explain:*

The use of remote supports and telehealth are not meant to replace the in-person supports for those individuals who require hands on or physical assistance. Individuals may receive supported employment or supported community living services in person or via telehealth.

How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service. *Explain:*

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 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.

How the telehealth will ensure the health and safety of an individual. *Explain:*

The individual's case manager 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 professional delivering HCBS via telehealth shall generate service documentation on each individual for the period when services are provided.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

1. For purposes of this section and section 249A.30 unless the context otherwise requires:
 - a. "Consumer" means an individual approved by the department to receive services under a waiver.
 - b. "Provider" means an agency certified by the department to provide services under a waiver.
 - c. "Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2. If a person is being considered by a provider for employment involving direct responsibility for a consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department (Department of Health and Human Services) shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the criminal background checks. The provider agency is responsible for completing the required waiver to perform the criminal background check and submitting to the Department of Public Safety who conducts the check. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of criminal background checks are available to the Department upon request. Iowa Medicaid will assure that criminal background checks have been completed through quality improvement activities on a random sampling of providers, focused onsite reviews and during the full on-site reviews conducted every 5 years.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. Site visits occur following provider enrollment, during targeted reviews and during the full onsite review. Screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. HHS also completes any evaluation needed for screenings returned with records or charges. Background checks only include Iowa unless the applicant is a resident of another state providing services in Iowa.

MCOs are contractually required to assure that all persons, whether they are employees, agents, subcontractors, or anyone acting for or on behalf of the MCO, are properly licensed, certified, or accredited as required under applicable state law and the Iowa Administrative Code. The Contractor shall provide standards for service providers

who are not otherwise licensed, certified, or accredited under state law or the Iowa Administrative Code.

- b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

1. For purposes of this section and section 249A.30 unless the context otherwise requires:
 - a. "Consumer" means an individual approved by the department to receive services under a waiver.
 - b. "Provider" means an agency certified by the department to provide services under a waiver.
 - c. "Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2. If a person is being considered by a provider for employment involving direct responsibility for a consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

All employees that provide direct services under the Consumer Choices Option under this waiver are required to complete child and dependent adult abuse background checks prior to employment with a member. The Fiscal Management provider completes the child and dependent adult abuse background checks and the employee will not pay for any services to the member prior to the completion of the checks.

The Iowa Department of Health and Human Services maintains the Central Abuse Registry. All child and dependent adult abuse checks are conducted by the HHS unit responsible for the intake, investigation, and finding of child and dependent adult abuse. The provider agency is responsible for completing the required abuse screening form and submitting it to HHS to conduct the screening. Providers are required to complete the child and dependent adult abuse background checks of all staff that provides direct services to waiver members prior to employment. Providers are required to have written policies and procedures for the screening of personnel for child and dependent adult abuse checks prior to employment. As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the child and dependent adult abuse checks. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of child and dependent adult abuse checks are available to the Department upon request. The Department will assure that the child and dependent adult abuse checks have been completed through the Department's quality improvement activities of random sampling of providers, focused onsite reviews, initial certification and periodic reviews and during the full on-site reviews conducted every 5 years.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during

provider site visits to ensure screenings have been completed. Screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. HHS also completes any evaluation needed for screenings returned with records or charges. MCOs are also required to ensure that all required screening is conducted for providers who are not employees of a provider agency or licensed/accredited by a board that conducts background checks (i.e., non-agency affiliated self-direction service providers). HHS retains final authority to determine if an employee may work in a particular program.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

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

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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 or subcontractor of a Supported Community Living (SCL) provider agency, Attendant Care agency, or an employee under the Consumer Choices Option (CCO) program. When the legally responsible person is the SCL, Attendant Care 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, attendant care or CCO, the legally responsible person must have the skills needed to provide the services to the member. In many situations, the member requests the legally responsible person to provide services, as the legally responsible person knows the member and their needs best. In other circumstances, there are no other qualified providers available when the service is needed or a lack of staff in the area to provide the service.

Through the person-centered planning process, the comprehensive service plan is developed. If the member has a guardian who is also their service provider, the care plan will address how the HHS case manager or MCO community-based case manager will oversee the service provision to ensure care is delivered in the best interest of the member.

The rate of pay and the care provided by the legally responsible person is identified and authorized in the member’s plan of care that is authorized and monitored by a HHS case manager or MCO community-based case manager. Service plans are monitored to assure that authorized services are received. For fee-for-service members, the State completes post utilization audits on waiver providers verifying those services rendered match the service plan and claim process. In addition, information on paid claims for fee-for-service members are available in IoWANS for review. The IoWANS system compares the submitted claims to the services authorized in the plan of care prior to payment. The claim will not be paid if there is a discrepancy between the amount billed and the rate of pay authorized in the plan. MCOs are responsible for ensuring the provision of services by a legally responsible individual is in the best interest of the member and that payments are made only for services rendered. All participants must participate in a training program prior to assuming self-direction, and MCOs provide ongoing training upon request and/or if it is determined a participant needs additional training. MCOs monitor the quality-of-service delivery and the health, safety and welfare of members participating in self-direction, including implementation of the back-up plan. If problems are identified, a self-assessment is completed to determine what additional supports, if any, could be made available. MCOs must ensure payments are made only for services rendered through the development and implementation of a contractually required program integrity plan. The HHS maintains oversight of the MCO program integrity plans and responsibility for overall quality monitoring and oversight.

- 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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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 employee under the CCO program, or an employee hired by an attendant care provider agency. When the legal representative is the SCL, attendant care 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 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 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 provider agencies and self-directed services. MCOs are required to adhere to all state policies, procedures, and regulations regarding payment to legal guardians, as outlined in this section.

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

Iowa Medicaid providers will be responsible for providing services to fee-for-service members. The Iowa Medicaid Provider Services Department markets provider enrollment for Iowa Medicaid. Potential providers may access an application on line through the website or by calling the provider services' phone number. Iowa Medicaid Provider Services Unit must respond in writing within five working days once a provider enrollment application is received, and must either accept the enrollment application and approve the provider as a Medicaid provider or request more information. In addition, waiver quality assurance staff and waiver program managers, as well as county and State service workers, case managers, health home coordinators, market to qualified providers to enroll in Medicaid.

MCOs are responsible for oversight of their provider networks.

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

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

No, the state does not choose the option to provide HCBS in acute care hospitals.

Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. *By checking the boxes below, the state assures:*

The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;

The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;

The HCBS must be identified in the individual's person-centered service plan; and

The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

And specify: (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting; (b) How the 1915(c) HCBS will assist the individual in returning to the community; and (c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: *The state verifies that providers initially and continually meet required licensure and/or*

certification standards and adhere to other standards prior to their furnishing waiver services.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

QP-a1: Number and percent of newly enrolled waiver providers verified against the appropriate licensing or certification standards prior to furnishing services.

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

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 10px;"></div>	
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Data Source (Select one):

Other

If 'Other' is selected, specify:

Encounter data, claims data and enrollment information out of IoWANS. All MCO HCBS providers must be enrolled as verified by Iowa Medicaid PS.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;">Contracted entity including MCO</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 10px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 10px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 10px;"></div>	

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Re-enrollment information out of IoWANS. All MCO HCBS Providers must be re-enrolled as verified by Iowa Medicaid Provider Services unit every 5 years.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>

Other Specify: <input type="text" value="Contracted entity"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

b. Sub-Assurance: *The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.*

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

QP-b1: Number and percent of non-licensed/noncertified providers that met waiver requirements prior to direct service delivery. Numerator = # of non-licensed/noncertified providers who met waiver requirements prior to direct service delivery; Denominator = # of non-licensed/noncertified providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Enrollment Records, IoWANS, Claims

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

Data Aggregation and Analysis:

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

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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>

Other Specify: <input type="text" value="FMS Provider"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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 = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Contracted</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

Iowa Medicaid Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment.

All MCO providers must be enrolled as verified by Iowa Medicaid Provider Services.

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

If it is discovered by Provider Services Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, the provider is required to correct deficiency prior to enrollment or reenrollment approval. Until the provider make these corrections, they are ineligible to provide services to waiver members. All MCO providers must be enrolled as verified by Iowa Medicaid Provider Services, so if the provider is no longer enrolled by the Iowa Medicaid then that provider is no longer eligible to enroll with an MCO.

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

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

PMs QP-a1, QP-a2, QP-b1, QP-b2, QP-b3 discovery process includes reviewing the provider's qualifications prior to enrollment and upon reenrollment. Provider qualifications include ensuring that the provider is performing child and dependent adult abuse checks and criminal record checks in accordance with Code of Iowa 135C.33

<https://www.legis.iowa.gov/docs/code/2019/135C.33.pdf>, 441 Iowa Administrative Code 79.14

<https://www.legis.iowa.gov/docs/iac/chapter/441.79.pdf> and 441 IAC 119 <https://www.legis.iowa.gov/docs/iac/chapter/09-25-2019.441.119.pdf>

ii. Remediation Data Aggregation

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>contracted entity and MCO</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional

limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

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

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

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

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR

08/15/2025

441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are received. (*Specify and describe the types of settings in which waiver services are received.*)

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 in the future as part of ongoing monitoring. (*Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.*)

3. By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:

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, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

The setting is selected by the individual from among 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. (*see Appendix D-1-d-ii*)

Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

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.

Facilitates individual choice regarding services and supports, and who provides them.

Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

No, the waiver does not include provider-owned or controlled settings.

Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, in addition to meeting the above requirements, will meet the following additional conditions):

The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Each individual has privacy in their sleeping or living unit:

Units have entrance doors lockable by the individual.

Only appropriate staff have keys to unit entrance doors.

Individuals sharing units have a choice of roommates in that setting.

Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Individuals have the freedom and support to control their own schedules and activities.

Individuals have access to food at any time.

Individuals are able to have visitors of their choosing at any time.

The setting is physically accessible to the individual.

Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan(see *Appendix D-1-d-ii of this waiver application*).

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. (*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:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Integrated Health Homes, through their Care Coordinators, are responsible for service planning functions for those members enrolled with an IHH. IHH care coordinators must meet the requirements as outlined in the approved Health Home SPA Attachment H, SPMI: The Care Coordinator must be a BSW with an active license, or BS/BA in the related field.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

- b. Service Plan Development Safeguards.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the

option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- Direct oversight of the process or periodic evaluation by a state agency;**
- Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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, health home coordinator, or community-based case manager; service providers; and other supporting persons selected by the member. During service plan development, the member and/or their representative is strongly encouraged to engage in an informed choice of services, and is offered a choice of institutional or HCBS. Planning is timely, occurs when convenient for the member, and is intended to reflect the member's cultural considerations. If the member chooses to self-direct services, an Independent Support Broker is provided to assist with budgeting and employer functions. The Iowa Medicaid Member Services Unit remains available at all times, during normal business hours, to answer questions and offer support to all Medicaid members. Further, the Member Services Unit distributes a quarterly newsletter in effort to continually educate waiver members about services and supports that are available but may not have been identified during the service plan development process.

The interRAI Standardized Assessment Tool and the Mayo Portland Adaptability Inventory (MPAI) or other department designated standardized assessment tool is completed prior to the initiation of services and yearly thereafter for fee-for-service (FFS) and MCO members. These tools are provided to the member upon request and are utilized by the member, their case manager and their IDT during the service planning meeting to identify priority needs and goals in order to develop the member's comprehensive person centered service plan.

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 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.

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 individual 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.
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Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. **i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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; case manager or health home coordinator; and an interdisciplinary team. Planning meetings are scheduled at times and locations convenient for the individual. 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 or health home coordinator receives the assessment and level of care determination from medical services. A summary of the assessment becomes part of the service plan. The case manager or health home coordinator 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 types of assessments used are identified in Appendix B-6-e.

The case manager or health home coordinator 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. 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 HHS TCM, 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 participant's plan of care.

The case manager or health home coordinator 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:

- a. Reflect that the setting in which the individual resides is chosen by the member;
- b. Reflect the member's strengths and preferences;
- c. Reflect the clinical and support needs as identified through the needs assessment;
- d. Include individually identified goals and desired outcomes which are observable and measurable;
- e. Include the interventions and supports needed to meet member goals and incremental action steps as appropriate;
- f. Reflect the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- g. 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;
- h. 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;
- i. 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);
- j. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- k. Include a plan for emergencies;
- l. Be understandable to the member receiving services and supports, and the individuals important in supporting him or her;
- m. Identify the individual and/or entity responsible for monitoring the plan;
- n. 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;
- o. Be distributed to the member and other people involved in the plan;
- p. Indicate if the member has elected to self-direct services and, as applicable, which services the participant elects to self-direct; and
- q. Prevent the provision of unnecessary or inappropriate services and supports.

The case manager or health home coordinator 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 or health home coordinator 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 individual. 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.

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:

- a. Reflect that the setting in which the individual resides is chosen by the member;
- b. Reflect the member's strengths and preferences;
- c. Reflect the clinical and support needs as identified through the needs assessment;
- d. Include individually identified goals and desired outcomes which are observable and measurable;
- e. Include the interventions and supports needed to meet member goals and incremental action steps as appropriate;
- f. Reflect the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- g. 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;
- h. 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;
- i. 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);
- j. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- k. Include a plan for emergencies;
- l. Be understandable to the member receiving services and supports, and the individuals important in supporting him or her;
- m. Identify the individual and/or entity responsible for monitoring the plan;
- n. 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;
- o. Be distributed to the member and other people involved in the plan;
- p. Indicate if the member has elected to self-direct services and, as applicable, which services the participant elects to self-direct; and
- q. Prevent the provision of unnecessary or inappropriate services and supports.

MCO members have appeal rights, including access to a State Fair Hearing after exhausting the MCO appeal process. Members can continue services while an appeal decision is pending, when the conditions of 42 CFR 438.420 are met. MCOs are contractually required to implement a comprehensive strategy to ensure a seamless transition of services during program implementation. Further, MCOs are required to develop and maintain, subject to HHS approval, a strategy and timeline within which all waiver members will receive an in-person visit from appropriate MCO staff and an updated needs assessment and service plan. Services may not be reduced, modified or terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. Changes to these must receive HHS prior approval.

- ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

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.

For provider owned or controlled settings, any modification of the additional conditions under 42 CFR §

441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:

A specific and individualized assessed need for the modification.

Positive interventions and supports used prior to any modifications to the person-centered service plan.

Less intrusive methods of meeting the need that have been tried but did not work.

A clear description of the condition that is directly proportionate to the specific assessed need.

Regular collection and review of data to measure the ongoing effectiveness of the modification.

Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

Informed consent of the individual.

An assurance that interventions and supports will cause no harm to the individual.

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 or integrated health home care coordinator, 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 participant 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 participant or other persons or significant amounts of property damage. The 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.

Emergency plans are developed on the following basis:

- Providers must provide for emergency, back-up staff in applicable services.
- Interdisciplinary teams must identify in the service plan, as appropriate for the individual member health and safety issues based on information gathered prior to the team meeting, including a risk assessment. This information is incorporated into the service plan.
- The team identifies 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.

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 when a scheduled support worker does not appear. Other providers may be listed on the service plan as source of back up as well. All participants choosing the self-direction option will sign an individual risk agreement that permits the participant to acknowledge and accept certain responsibilities for addressing risks.

MCOs have processes to ensure the necessary risk assessments and mitigation plans are completed and made available to all parties. Risk assessments and mitigation plans are completed during the individual's service plan (ISP) team meeting. The IHH determines a member's risk through a series of questions and answers. Findings are documented in the Person Centered Treatment Plan. This form guides the IHH to identify member's personal preferences for risk mitigation including back-up arrangements. The IHH Care Coordinator leads the ISP meeting, ensuring that there is a back-up arrangement for each service identified. The member, ISP team members, and ancillary providers receive a copy of the plan.

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 Medicaid website, MCO website, and/or MCO member services call center, the case manager, health home coordinator, 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 the available providers before making a selection. Members are not restricted to choosing providers within their community. Information about qualified and accessible providers is also available to members through their case manager, health home coordinator, community-based case manager, Iowa Medicaid website, and/or MCO website. 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 the 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 participants. (Refer to appendix A and H for IoWANS system processes.) On a monthly basis, the Iowa Medicaid Medical Services Unit conducts service plan reviews. The selection size for the waiver has a 95% confidence level. This info is reported to CMS as part of Iowa's performance measures. IoWANS will only be utilized for fee-for-service members and quality data for managed care participants will be provided by the MCOs.

The State retains oversight of the MCO service plan process through a variety of monitoring and oversight strategies as described in Appendix D – Quality Improvement: Service Plan section. On a monthly basis, each managed care organization conducts service plan reviews. The selection size for the waiver requires a 95% confidence level. The monthly info gathered by the MCOs is reported to Iowa Medicaid managed care Unit on a quarterly basis for review. Iowa Medicaid reviews the MCO service plan information and reports to CMS as part of Iowa's performance measures.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, 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, or health home coordinators 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.

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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

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

As part of HCBS waiver enrollment, case management is required for each participant, regardless of delivery system. Following the first three months, the Case Managers must complete at least one contact per month with the individual or their authorized representative 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. This contact may be face-to-face, virtual, or via telehealth. Written communication does not constitute contact unless there are extenuating circumstances outlined in the enrollee's individualized service plan (ISP).

- If the individual has been diagnosed with an Intellectual and/or Developmental Disability, Case Managers must complete at least one, in-home, face-to-face contact every other month
- For those who are not diagnosed with Intellectual and/or Developmental Disability, the Case Manager must complete at least one, in-home, face-to-face contact every three months.

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 including access and use of non-waiver services including health services.
- Participating 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 or health home coordinator, 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 QA 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, or health home coordinator 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.

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 plans at a 95% confidence level. These reviews focus on the plan development, implementation, monitoring, and documentation that is completed by the case manager.

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 including access to waiver and non-waiver services, the quality of service delivery including access and use of non-waiver services including health services, and the health, safety and welfare of members and choice of service providers. Information about monitoring results are compiled and reported by the MCO on a quarterly basis. 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.

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.

- b. Monitoring Safeguard.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation. *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

- Direct oversight of the process or periodic evaluation by a state agency;
- Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
- Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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 = <div>95% confidence level with a +/- 5% margin of error</div>
Other Specify: <div>Contracted entity including MCO</div>	Annually	Stratified Describe Group: <div> IA.0213 AIDS/HIV (.05%) IA.0242 ID (47%) IA.0299 BI (6%) IA.0345 PD (4%) IA.0819 CMH (4%) IA.4111 HD Waiver (9%) IA.4155 - Elderly Waiver (30%) </div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- b. Sub-assurance:** *Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.*

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

	Specify: <div></div>	
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Data Aggregation and Analysis:

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

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 (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95% confidence level with a +/- 5% margin of error</div>
Other Specify: <div>Contracted entity including MCO</div>	Annually	Stratified Describe Group: <div> IA.0213 AIDS/HIV (.05%) IA.0242 ID (47%) IA.0299 BI (6%) IA.0345 PD (4%) IA.0819 CMH (4%) IA.4111 HD Waiver (9%) IA.4155 - Elderly Waiver (30%) </div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly

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: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

e. *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.

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 and MCO CAHPS databases

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
---	--	--

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95% confidence level with a +/- 5% margin of error</div>
Other Specify: <div>Contracted entity including MCO</div>	Annually	Stratified Describe Group: <div> IA.0213 AIDS/HIV (.05%) IA.0242 ID (47%) IA.0299 BI (6%) IA.0345 PD (4%) IA.0819 CMH (4%) IA.4111 HD Waiver (9%) IA.4155 - Elderly Waiver (30%) </div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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: 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 (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

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

Data Aggregation and Analysis:

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

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

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

The 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 oversight of service plans for their members.

The HCBS Quality Oversight Unit has identified 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. Person Centered Planning is also monitored by the HCBS QA Unit through the MCO Community Based Case Managed (CMCB) Interdisciplinary Team (IDT) Ride Along process. The QA staff participates in a random selection of IDT meetings and then follows up to ensure that the final authorized plan agrees with the plan agreed upon by the IDT.

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

MCO

MCOs are responsible for monitoring the implementation of the 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. 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 including access to waiver and non-waiver services, the quality of service delivery including access and use of non-waiver services including health services, and the health, safety and welfare of members and choice of service providers. Information about monitoring results are compiled and reported by the MCO on a quarterly basis. 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.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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 oversight of service plans for their members.

The HCBS Quality Oversight Unit has identified 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(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: Contracted entity including 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 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.

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 the Consumer Choices Option (CCO) for participant direction. There is no difference in how the CCO works with the MCO and FFS members. The MCO per member/per month capitation does not affect the self-direction process; and the capitation does not affect the amount of budget available to the member.

Consumer Choices Option (CCO)

The CCO offers both employer and budget authority to the member self-directing services. At the time of service plan development and/or at the member's request, the member has the option to convert the following services into an individualized self-direction budget based on services that are authorized in their service plan: (1) attendant care (unskilled); (2) adult day care; (3) home and vehicle modification; (4) prevocational services; (5) basic individual respite care; (6) specialized medical equipment; (7) supported community living; (8) supported employment; and (9) transportation.

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 four types of self-direction services to meet their assessed needs: (1) self-directed personal care services; (2) self-directed community supports and employment; (3) individual-directed goods and services (4) independent support broker.

If any of these options are elected, Financial Management Service (FMS), by Sate administrative rule, must be involved. The member may elect to receive assistance with budget development through an Independent Support Broker (ISB) or their Case Manager. Two budgets will be developed as a result of the service plan development traditional services budget (includes traditional services for which the member does not have budget or employer authority) and the individual budget (includes services and supports for which the member does have budget and employer authority). Self-directed personal care services are services and/or goods that provide a range of assistance in the member's home or community, as well as activities of daily living and incidental activities of daily living that help the member remain in their home and in their community. 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 service plan. The item 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: (1) contract with entities to provide services and support; (2) 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); (3) schedule the provision for services; (4) authorize payment for waiver goods and services identified in the individual budget; and (5) 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 will 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. For example, the ISB may help develop a monthly budget, recruit and interview potential employees, or assist with required paperwork. 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.

Per 441 Iowa Administrative Code 78.34(13)"k," the ISB "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."

Members will also work with an FMS provider that will receive Medicaid funds on behalf of the member. The FMS is a Medicaid provider, and receives an electronic funds transfer (EFT) on a monthly basis for the member's monthly budget. The FMS is responsible for paying all employer taxes as required. Employees of the member are required to submit timecards within thirty days of providing the service for payment. The member's monthly budget includes a monthly per member, per month fee for the FMS provider, with the remainder designated for the purchase of goods and services for the participant. Per 441 Iowa Administrative Code 78.34(13)"1," the FMS "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:
 - a. Verifying that hourly wages comply with federal and state labor rules.
 - b. Collecting and processing timecards.
 - c. 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.
 - d. Computing and processing other withholdings, as applicable.
 - e. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 - f. Preparing and issuing employee payroll checks.
 - g. Preparing and disbursing IRS Forms W-2 and W-3 annually.
 - h. Processing federal advance earned income tax credit for eligible employees.
 - i. Refunding over-collected FICA, when appropriate.
 - j. 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

A utilization adjustment factor (UAF) is used to adjust the CCO budget to reflect statewide average cost and usage of waiver services. Annually, the Department determines the average cost for each waiver service. The average service cost is used to determine the “cap amount” of the CCO budget. The cap amount is used to ensure the member stays within the program dollar cap limits within each waiver. The department also determines the percentage of services that are used, compared to what is authorized within a waiver service plan. This percentage is applied to the cap amount to determine the CCO “budget amount”. The budget amount is the total funds available to the member in the monthly CCO budget. This UAF includes all HCBS waiver members in the calculation, not just members participating in CCO.

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.

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 participant residing in their own home, with family, in a residential care facility, or in a four to five person home in the community. In accordance with Iowa Code 135C.6(c) and 441 Iowa Administrative Code 77, 77.37(14), and 77.39(13) the waiver program allows for up to four individual receiving HCBS to reside together in one living unit; five individuals may live together in one living unit with department approval for the location. The five person homes are required to be licensed by DIAL as a residential care facility or require approval by HHS. CCO is allowed in these units of five persons.

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 member 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 and Iowa Medicaid 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.

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 members’ 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, when chosen, the Independent Support Broker provides monitoring of health and safety. The member’s case manager or CBCM is responsible to assess individual needs and monitor service delivery to assure that the member’s health and safety are being addressed. Case managers and CBCMs 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
Individual Directed Goods and Services		
Home and Vehicle Modification		
Specialized Medical Equipment		
Medical Day Care for Children		
Supported Community Living		

Waiver Service	Employer Authority	Budget Authority
Supported Employment		
Skilled Attendant Care		
Attendant Care		
Independent Support Broker		
Prevocational Services		
Adult Day Care		
Transportation		
Respite		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

Financial Management Services

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Entities providing FMS must be cooperative, not-for-profit member owned and controlled, federally insured financial institution that is and 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 chartered by the Office of the Comptroller of the Currency, a Bureau of the United States Department of the Treasury, is a member of the Federal Reserve; and/or is federally insured by the Federal Deposit Corporation. Further, the entity must be enrolled as a Medicaid provider. Once enrolled and approved as a Medicaid provider, the FMS will receive Medicaid funds in an electronic transfer and will pay all service providers and employees electing the self-direction option.

MCOs are responsible for contracting with an FMS entity or entities to assist members who elect to self-direct. All MCO contracted FMS entities must meet the requirements documented in this section. Under the managed care delivery system, the FMS entity contracted with the MCO is responsible for the same functions as under the fee-for-service model.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS entities are paid a monthly fee for their services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

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 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 waiver member with information and assistance with choosing the CCO program 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 conducts regular CCO webinars 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.

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
Interim Medical Monitoring and Treatment (IMMT)	
Individual Directed Goods and Services	
Home and Vehicle Modification	
Positive Behavioral Support and Consultation	
Specialized Medical Equipment	
Medical Day Care for Children	
Supported Community Living	
Supported Employment	
Skilled Attendant Care	
Case Management	
Attendant Care	
Independent Support Broker	
Prevocational Services	
Adult Day Care	
Enabling Technology for Remote Support	
Transportation	
Personal Emergency Response System or Portable Locator System	
Financial Management Service	
Family Training Services	
Respite	

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 case managers, 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 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)

I. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Members may receive traditional waiver services, as well as services and supports under an individual budget for self-direction. Any waiver member may voluntarily discontinue the self-direction option at any time, regardless of delivery system (FFS members or MCO members). The member will continue to be eligible for services as specified in the service plan, regardless of whether they select the self-direction option. A new service plan will be developed if the member's needs change or if they voluntarily discontinue the self-direction option. The case manager or community-based case manager will work with the member to ensure that services are in place and that 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 enrollees, case manager 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 t 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.

MCOs may only initiate involuntarily termination of a member’s use of the self-direction option if there is evidence of Medicaid fraud or misuse of funds, or if the MCO determines there is a risk to the member’s health or safety. Under these conditions, MCOs are required to submit a request to HHS for review and approval to involuntarily terminate. Requests must contain sufficient documentation regarding the rationale for termination. Upon HHS approval, MCOs must notify the member and facilitate a seamless transition to traditional waiver services to ensure there are no interruptions or gaps in service delivery.

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	<div></div>	<div>580</div>
Year 2	<div></div>	<div>600</div>
Year 3	<div></div>	<div>620</div>
Year 4	<div></div>	<div>640</div>
Year 5	<div></div>	<div>660</div>

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 member who will provide care for a participant. The State pays for the first background check of workers who provide waiver services to fee-for-service participants. 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:

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 waiver, the member chooses a service provider from a list of providers who are enrolled with Iowa Medicaid. The case manager and member work together to detail the tasks and goals for the provider. After service provision, the provider submits a claim to 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 have enrolled with Iowa Medicaid. The member is considered the employer and can choose any individual that they feel is qualified to provide the needed service. Members create support plans, make provider and service choices, select and employ staff, and monitor the quality of support services. MCOs are responsible for assisting the member with quality assurance activities and monitoring the quality of services provided. MCO plans to accomplish this contractual requirement are subject to HHS review and approval. Members determine the wages to be paid to the provider and the units of service (limited by the self-direction budget). Interviewing, hiring, scheduling, and firing is done by the member. Claims are submitted to the FMS for processing for payment.

Each member who chooses to self-direct their services will continue to have a traditional service plan developed that is based on the level of care assessment and need of the member. If a member has a need for the services that can be included in the individual budget and they choose to self-direct one or all of those services, then the individual budget amount is determined by the amount of service that was authorized for those services under the traditional service plan. The level of need is determined by the level of care determination made by Iowa Medicaid QIO MSU; the supports needed and the amount of supports needed are determined by a review of the assessment made by the case manager, or CBCM prior to the member selecting the self-direction option. Members who reside in an assisted living facility may also choose to self-direct some of their services. Specifically, the member can choose to self-direct services not provided by the facility (i.e., vehicle modification) or can choose another provider for services that are optional from the facility (i.e., meals or housekeeping).

Historically, members do not use 100% of their authorized waiver services. To ensure that the State or MCO does not spend more than what is historically spent for traditional waiver services, each service authorized under self-direction will have a utilization adjustment factor applied to it. This utilization adjustment factor is determined by an analysis of what percentage of authorized services has historically been used for each service on an aggregate by all members enrolled in that particular waiver who have accessed that particular service. The utilization factor is not based upon individual member usage, but on historical percentage usage of authorized services by all members enrolled in the waiver who have accessed that particular service. A member new to the waiver or new to self-direction would have the same utilization factor applied as all other waiver members who are self-directing services. The utilization adjustment factor will be analyzed, at a minimum, every 12 months and adjusted as needed based historical use. This method will be used for all waiver members choosing the self-direction option. Members are notified of the budget methodology and limits at the time they receive the CCO Booklet, during their service plan is development and by the Independent Support Broker hired to assist the individual to develop the budget. The individual budget 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.

The following is an example of how an individual budget is determined:

A member has a need for a particular service. On their traditional service plan they are authorized 10 units of service at \$20 a unit. That member decides that they would like to self-direct their services. The amount authorized is \$200 in the traditional service plan. A utilization adjustment factor of 80% is applied. The member's individual budget amount then becomes \$160 ($\$200 \times 80\%$). The 20% reduction (100% authorization minus 80% actual utilization for a service) is applied to allow for cost neutrality between the service under the traditional waiver plan and self-direction. If the average service utilization is only 80% of an authorized service under the traditional waiver, then a self-directed member is limited to that same 80% to preserve cost neutrality. The total monthly cost of all services (traditional and self-directed services) cannot exceed the established aggregate monthly cost of the traditional services authorized.

If there is a need that goes beyond the budget amount and/or the waiver service limit, the member has the right to request a Waiver to Iowa Administrative Code (IAC). Waiver to IAC may be granted to the requestor when the member has needs beyond the limits expressed in the Iowa Administrative Code. For fee-for-service members

this decision is made by the Director of HHS, based on an evaluation of the member's needs in relation to the State's necessity to remain within the waiver's parameters of cost neutrality. The process to request a Waiver to IAC is shared on the HHS website as well as with the member when they apply for waiver services. In addition, any member has the right to appeal any decision made by HHS and to request an appeal hearing by an administrative law judge. The member is afforded the opportunity to request a fair hearing when the budget adjustment is denied or the amount of budget is reduced as described in F-1.

The MCOs operate an exception to policy process for their members. In the event an MCO denies an exception to policy and determines the member can no longer have his or her needs safely met through the 1915(c) waiver, the MCO is required to forward this information to HHS. In addition, MCO members have the right to appeal any decision made by the MCO and may appeal to the HHS once the MCO appeals process has been exhausted as described in F-1.

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 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 a review of the service plan.

As noted above, if there is a need that goes beyond the budget amount and/or the waiver service limit, the member has the right to request a Waiver to IAC. In addition, any member has the right to appeal any decision. The member is afforded the opportunity to request a fair hearing when the budget adjustment 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 and community-based 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. This budget amount is the same amount whether the member utilizes only traditional waiver services, utilizes only self-directed services, or uses a combination of traditional and self-directed services. All services under the waiver add into the one budget and that budget maximum is determined by the member's level of care and not by the type of services accessed by the member.

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 service plan as long as it does not exceed the authorized budget amount. They 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:

Self-direction budgets are authorized monthly. Members, regardless of delivery system (i.e., FFS members and MCO members), can make adjustments at any time within the authorized amount if services are not meeting their needs, and the ISB via the FFS or MCO delivery system is available to provide assistance. The ISB also routinely monitors expenses. The FMS also monitors the budget and notifies the ISB and the member immediately if claims are inconsistent with the budgeted amount or if the budget is consistently underutilized. 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.

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.

FEE FOR SERVICE:

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 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, integrated health care coordinator, community-based case manager, and/or 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.

The choice of HCBS vs. institutional services is discussed with the member at the time of the completion of the application by HHS income maintenance staff; and again at the time of the service plan development by the case manager, integrated health care coordinator, or community-based case manager. 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.

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 Notice of Hearing. 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, integrated health care coordinator, 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.
Iowa Total Care: 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

- **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

- **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 Assurance and Technical Assistance 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.

- **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 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 Assurance and Technical Assistance 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 Assurance and Technical Assistance 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 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 critical 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

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 complete incident report form as follows:

- Forward a copy to the supervisor by the end of the next calendar day following the incident.
- Send a copy of the report to the member's case manager or community-based case manager (when applicable) and the BLTSS 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 involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services 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 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 incidents will be monitored and remediated by the HCBS Incident Reporting Specialist and HCBS specialists. On a quarterly basis, a 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 critical 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 critical incidents.
- Respond to critical incidents.
- Document critical 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 critical incident policies and procedures.
- Be subject to corrective action as needed to ensure provider compliance with critical incident requirements.

Finally, MCOs must identify and track critical incidents, and review and analyze critical 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 critical 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 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 that 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, 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 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 BLTC, 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 BLTSS meets biweekly to review critical incident reports of child and dependent adult abuse and member deaths that have been reported through the critical incident reporting process. HHS reviews, and if needed, requests information for follow through and resolution of the abuse allegation and member deaths from the case manager, community-based case manager, or HCBS Specialist. 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 Unit on a weekly basis until the situation has been resolved. HHS implemented a web-based critical incident reporting system September 1, 2009, that significantly enhanced the State's ability to track and trend the discovery, remediation, and improvement of the critical 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 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 critical incident management systems in accordance with the HHS requirements. 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 critical incidents. Network providers must provide training to direct care staff regarding the appropriate procedures for reporting, responding to, and documenting critical incidents.

Finally, MCOs must identify and track, review and analyze critical 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 critical 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.

HHS has oversight for monitoring incidents that affect all waiver members. An HCBS Quality Assurance and Technical Assistance 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. If the incident 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 will coordinate with PS. If PS is not investigating, the HCBS Specialist will begin an on-site review within two working days of receipt of the report. If it is determined that the member has been removed from immediate jeopardy, the review is initiated within twenty working days of receipt of report. 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 or MCO), 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 individual's body. Chemical restraints are most commonly used to calm an individual down in moments of escalation. Other examples of restraints include, but are not limited to, holding a person down with one's hands, tying an individual 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 what restraints are 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 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 them, and entered into the written plan of care with specific time lines. If a member were placed in a closed room the time frame would need to be determined on an individual basis and spelled out in the service plan. The provider would need to document the use of this restraint 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 HHS on the supervision and monitoring of members placed in a closed room, for example monitoring on a fifteen minute basis to assure the health and welfare of the member.

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 aversive 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. An employee's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each employee in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (i) the supervisor's ability to implement the procedure has been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Restraints and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter a member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements:

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the member's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the 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:

- 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 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. 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 Iowa Medicaid, which may include sanction, termination, required corrective action, 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 individual 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 Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restraints. 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 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 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 restraints. For fee-for-service members these reports are entered into IMPA, triggering milestones in IoWANS that alert case managers and prompting 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 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 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 restraints, 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.

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. 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.).

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:

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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 restrictions that may be used by waiver providers. A restrictive intervention is an action or procedure that limits a member's movement, access to other individuals, locations or activities, or restricts a member's rights. The use of any restrictive interventions 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 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."

These safeguards are the same regardless of what restrictions 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. Restrictions 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.

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 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 manager, community-based case manager are also required to submit critical incident reports to the BLTC care, 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 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 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 an member's behaviors.

Restrictions and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter a member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements:

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the member's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the member and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the 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. Restrictions 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 restrictions 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; 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 restriction 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 Iowa Medicaid, which may include sanction, termination, required corrective action, etc.

The member's case manager or community-based case manager, is responsible to monitor individual plans of care including the use of restrictions and behavioral interventions.

- 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 participant's movement, access to other individuals, locations or activities, or restricts a participant'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 individual 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 Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restrictions. 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 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 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 Unit for a targeted review. If the 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 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. 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.).

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 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. Seclusion can be considered on an individual basis after the interdisciplinary team reviews them, and are entered into the written plan of care with specific time lines. If a member were placed in a closed room, the time frame would need to be determined on an individual basis and spelled out in the service plan. The provider would need to document the use of this 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 HHS on the supervision and monitoring of members placed in a closed room, such as monitoring on a fifteen minute basis to assure the health and welfare of the member.

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 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 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 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 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 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 Iowa Medicaid, which may include sanction, termination, required corrective action, etc.

The member's case manager 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 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 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 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)*

- **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 77.46(5), respite providers must meet the following requirements as a condition of providing respite care under the 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 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 (most often monthly). The case manager or community-based case manager also monitor during the annual service plan development. MCO community-based case managers monitor the documentation of medication administration to ensure adherence to the service plan and provider policies and procedures.

Monitoring includes review of the service documentation to ensure that medications have been administered at the designated times and by designated individuals. Further monitoring occurs through the report of major incidents whenever a medication error results in physicians' treatment, mental health intervention, law enforcement intervention, death, or elopement. When a major incident has occurred, follow-up, investigation, and remediation occurs as identified in G.I.d. All medication errors resulting in a major incident report or discovered via complaint are fully investigated. If it is determined that a harmful practice has been detected, the provider agency completes a corrective action plan and may face sanctions depending on severity and negligence of the circumstance.

The Iowa Medicaid program has actively managed Medicaid pharmacy benefits through a Preferred Drug List (PDL) since 2005. A governor appointed medical assistance pharmaceutical and therapeutics (P&T) committee was established for the purpose of developing and providing ongoing review of the PDL. The prior authorization department of the Iowa Medicaid 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 an RCF/ID. All medical regimes are included in the member's record. Medications administered by the facility are recorded on a medical record by the individual who administers medication. All RCF/IDs are licensed facilities and must meet all Department of Inspections Administrative Rules to obtain an annually renewable license. Medical records are reviewed during licensure renewal. Persons administering medication must be a licensed nurse or physician or have successfully completed a department approved medication aide course. If the provider stores, handles, prescribes, dispenses, or administers prescription or over the counter medications the provider is required to develop procedures for the storage, handling, prescribing, dispensing, or administration of medication. For controlled substances, providers must maintain DIA procedures. If the provider has a physician on staff or under contract, the physician must review and document the provider's prescribed medication regime at least annually in accordance with current medical practice. Policies and procedures must be developed in written form by the provider for the dispensing, storage, and recording of all prescription and nonprescription medications administered, monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, including antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics. Policies and procedures are reviewed by the HCBS Specialists for compliance with state and federal regulations. If deficiencies are found, the provider is required to submit a corrective action, and follow-up surveys may be conducted based on the severity of the deficiency.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Second line responsibility is utilized when issues are more complex. Occurrences of high dosage use for certain medications or prescribing drugs for an age group where the drug is not FDA indicated are sent to Iowa Medicaid 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 members who have, historically, multiple prescribers and pharmacies. Identification of these members 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 member 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.

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.).

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 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 HCBS QIO Unit for a targeted review. If the HCBS QIO 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.

The HCBS QIO 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)*

- **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, supported employment, 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 Chapters 77.30(3)(b)(2), 77.33(6) (b)(2), 77.34(5) (b)(2), 77.37(15) (b)(2), 77.39(14) (b)(2), and 77.46(5)(e) state:

“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. 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 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.

- **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 member 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 member's case manager or community-based case manager when they occur. The case manager or community-based case manager monitors the errors and makes changes to the member'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 and 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 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:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The BLTSS 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 member 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 in the submitted amendment (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. These major incidents are reported to the department and follow the incident reporting follow up protocol of the department.

HHS contracts with the HCBS Quality Assurance 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 member 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 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 PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The 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 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

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.*

Performance Measures

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-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 = <input type="text"/>
Other Specify: <input type="text"/> Contracted entity including MCO	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
---	--	--

(check each that applies):		
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95% confidence level with a +/- 5% margin of error</div>
Other Specify: <div>MCO and contracted entity</div>	Annually	Stratified Describe Group: <div> IA.0213 AIDS/HIV (.05%) IA.0242 ID (47%) IA.0299 BI (6%) IA.0345 PD (4%) IA.0819 CMH (4%) IA.4111 HD Waiver (9%) IA.4155 - Elderly Waiver (30%) </div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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

Specify: Contracted entity including MCO		Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>MCO and contracted entity</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other Specify:	Annually	Stratified Describe Group:

Contracted Entity and MCOs		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

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 = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">Contracted Entity including MCO</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
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):
<div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- 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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

- 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):

Other

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 = <div>95% confidence level with +/- 5% margin of error</div>
Other Specify: <div>Contracted Entity</div>	Annually	Stratified Describe Group:

		IA.0299 - BI (6%) IA.0213- AIDS/HIV (.05%) IA.0242 - ID (47%) IA.0345 - PD (4%) IA.0819 - CMH (4%) IA.4111 - HD (9%) IA.4155 - Elderly (30%)
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	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 and each MCO is responsible for monitoring and analyzing data associated with the major incidents reported for members on waivers. For both FFS and MCO members, new Critical Incident Reports (CIRs) are reviewed on a daily basis and follow-up is initiated immediately; routine monitoring continues through resolution.

Data is pulled from the data warehouse and from MCO reporting on a regular basis for programmatic trends, individual issues and operational concerns. Reported incidents of abuse, medication error, death, rights restrictions, and restraints are investigated further by the HCBS Incident Reporting Specialist as each report is received. The analysis of this data is presented to the state on a quarterly basis.

The HCBS Quality Oversight Unit and 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.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The HCBS Incident Reporting Specialist and each MCO analyzes data for individual and systemic issues. Individual issues require communication with the case manager or community based case manager to document all efforts to remediate risk or concern. If these efforts are not successful, staff continues efforts to communicate with the case manager, the case manager's supervisor, and protective services when necessary. All remediation efforts of this type are documented in the monthly and quarterly reports.

The HCBS Specialists conducting interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. MCO are responsible for research and follow up to flagged responses.

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 Section 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 (QIS) 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. 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 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 <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div>Contracted Entities (Including MCOs)</div>	Other Specify: <div></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

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. The 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 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 Brain Injury Waiver services, including Personal Care services provided through the Consumer Choices Option (CCO) the state's self-direction program. Personal Care services are not treated differently from other waiver services.

Iowa Medicaid 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 BI waiver. Iowa Medicaid sends each MCO a monthly eligibility file called the 834 file. All current information for all members with eligibility in the upcoming month including demographic information is included in this file. The 834 file is used to identify member enrollment with the MCO for authorization of the capitated payment to the MCO. The eligibility file indicates any change in eligibility status, whether from FFS to MCO, MCO to FFS or a change from one MCO to another. Iowa Medicaid also sends each MCO a Long-Term Services and Supports File on a daily basis and monthly at months end which includes all current and historical information for members with HCBS Waiver or LTC eligibility in the upcoming month. The LTSS file is used to identify member enrollment in an HCBS Waiver who is assigned to the MCO for authorization of the capitated payment to the MCO.

The Iowa Medicaid 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 Medicaid Fraud and Control Unit (MFCU). The 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. Reviewed cases include providers who are outliers on multiple parameters of cost, utilization, quality of care, and/or other metrics. Reviews are also based on referrals and complaints received. Reviews include review of claims data and service documentation to detect such aberrancies as up-coding, unbundling, and billing for services not rendered. This monitoring may involve desk reviews or provider on-site reviews. During a desk review the provider is required to submit records for review. The PI vendor 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.

The PI vendor must report findings from all financial integrity monthly reviews to HHS, including monthly and quarterly written reports detailing information on provider review activity, findings and recoveries. Requests for provider records by the PI unit include a documentation checklist, listing the specific records that must be provided for the audit or review pursuant to Iowa Administrative Code to document the basis for services or activities provided. Reviews are conducted in accordance with Iowa Administrative Code.

The vast majority of HCBS claims are paid through MCOs. The Iowa Medicaid Program Integrity unit only reviews claims submitted through the Fee-For-Service (FFS) system for members who are not enrolled in an MCO. There are a relatively small number of HCBS claims in the FFS universe, and as such statistical sampling is unnecessary. It is more efficient and productive for the PI Unit to use more targeted strategies to identify providers for review, such as using data analysis and algorithms to identify billing aberrancies, as well as referrals and complaints that come from various sources. The PI vendor may conduct on-site reviews, but there is no requirement for a set percentage of reviews to be conducted on-site.

Should the State require a provider to perform a self-review, 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 letter and the FOR letter are reviewed and signed off by state PI staff prior to mailing. The FOR letter also 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 FFP being returned to CMS.

The 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 HHS 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 PI Plan must be updated annually and submitted to HHS for review and approval. The MCOs are also required to make referral to Iowa Medicaid and the MFCU for any suspected fraudulent activity by a provider. On a monthly basis, the MCO must submit an activity report to HHS, 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 Iowa Medicaid PI Unit, the Iowa Medicaid 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.

As part of the EQR process, the contractor performs onsite reviews of the MCOs that include processes that impact BI Waiver providers and members. Reviews include credentialing files, critical processes such as service authorization validation, claims processing, training and care coordination.

The State reviews monthly, quarterly, annual reports and compliance plans to provide oversight on the MCO programs. Each MCO has meetings monthly with the State and the Medicaid Fraud Control Unit (MFCU) to review fraud waste and abuse referral information and provide any updates regarding open investigations. Monthly fraud waste and abuse referrals, audits/investigations, closed cases, overpayment letters, overpayments collected, among other numerical values are tracked and trended with the previous year's data on a dashboard updated monthly. There will be on-site audits beginning in SFY20 for MCO oversight to validate correct reporting. These types of audits will be on a regular basis. The State will begin a program integrity review of MCO claims to ensure providers are billing and rendering services appropriately. The State will notify the MCOs of any review findings for them to pursue further program integrity activities with the provider.

MCOs must also coordinate all PI efforts with Iowa Medicaid and Iowa's MFCU. MCOs must have in place a method to verify whether services reimbursed were actually furnished to members as billed by providers and must comply with 42 CFR Part 455 by suspending payments to a provider after HHS determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual/entity unless otherwise directed by HHS 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. All HCBS cost reports will be subject to 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, T1002-IMMT HHA RN Services 15 Minutes, T1003-IMMT HHA LPN/LVN Services Up To 15 Minutes, and T1004-IMMT SCL 15 Minutes.

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 state's quality improvement strategy, provide information in the following fields to detail the state's 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.

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

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 = <div>95% confidence level with +/- 5% margin of error</div>
Other Specify: <div>Contracted entity</div>	Annually	Stratified Describe Group:

		IA.0213 AIDS/HIV (.05%) IA.0242 ID (47%) IA.0299 BI (6%) IA.0345 PD (4%) IA.0819 CMH (4%) IA.4111 HD Waiver (9%) IA.4155 - Elderly Waiver (30%)
	Continuously and Ongoing	Other Specify: <div> Reviewed monthly by pulling a sample of claims from the two most utilized codes per waiver the 1st qtr., remaining qtrs. will include claims from other codes in the waiver, ranked by utilization. </div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>

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

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:

The DW 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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

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	Frequency of data collection/generation	Sampling Approach (check each that applies):
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<i>(check each that applies):</i>	<i>(check each that applies):</i>	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; display: inline-block;">Contracted Entity including MCO</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	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: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

FA-b1: 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:

MMIS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other	Annually	Stratified

Specify: <input type="text" value="contracted entity"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

The 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 state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments; require screening of all claims, referral to MFCU, or provider suspension.

The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a quarterly basis.

If during the review of capitation payments Iowa Medicaid determines that a capitation was made in error, that claim is adjusted to create a corrected payment.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 Iowa Administrative Code (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 HHS Iowa Medicaid’s methodology without making any additional charge to the member. Reimbursement types are described at 441 IAC 79.1(1),

Supported community living rates are based on a retrospectively limited prospective rate configured Iowa Medicaid’s rate setting unit in coordination with the provider.

Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1)“e”(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider’s reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) 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. If a BI Waiver provider’s payments for Medicaid-covered services exceed the actual Medicaid costs for services adjusted for the legislative inflation percentage, HHS Iowa Medicaid will recoup the overpayment by requiring the BI Waiver provider will return an amount equal to the overpayment to the Iowa Medicaid, and Iowa Medicaid will make an offsetting adjustment to the CMS-64

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

PERS, behavior programming, family counseling and training, adult day care, case management, medical day care for children, enabling technology, prevocational service, supported employment, respite, specialized medical equipment, HVM, transportation and FMS are reimbursed by fee schedules.

Respite provided by home health agencies is based on the provider’s rate in effect 6/30/16 plus 1%, converted to a 15 minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15 minute rate or maximum Medicaid rate in effect 6/30/16 plus 1% converted to a 15 minute rate. Variations in fee schedule rates for Respite services are based on the type of provider delivering the respite services.

Agency Attendant Care (Skilled and Unskilled) providers are reimbursed on the basis of the agreement of the member and the provider not to exceed the upper payment limit in IAC. The rate determination for self-directed services, under CCO, are reimbursed according to the methodology in section E-1-a.

For the FMS and ISB services, the IM sets the upper rate limit for those services as established in IAC 441-79.1(2).

IMMT 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 minute units since the service costs for both SCL and IMMT are the same or very similar. Iowa Medicaid utilizes claim system edits to prevent payment to the SCL/IMMT providers for IMMT and daily SCL on the same date of service. HHS Iowa Medicaid uses different Healthcare common procedure codes and level II modifiers to distinguish the IMMT service rendered by a daily SCL provider and the daily SCL service rendered by the same provider. 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.

For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare. For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined

by HHS Iowa Medicaid according to the Medicare reimbursement method described in section 1834(a) of the Social Security Act (42 U.S.C. 1395m), payment for durable medical equipment. Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent. Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

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. 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, or postage.

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 BI 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.

During service plan development, the CM shares with the member the rates of the providers, and the member can choose 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.

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. HCBS reimbursement rates were last increased for dates of service beginning July 1, 2024.

Oversight of the rate determination process is conducted by Iowa Medicaid. The Iowa Medicaid 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 Iowa Medicaid 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>.

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.

Effective November 1, 2023, the following services may be rendered via telehealth under this waiver: Behavioral Programming, Case Management, SCL, and SE. When services are delivered via telehealth, reimbursement is the same as if the services were rendered in person.

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

- 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 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, and shall be processed by the Iowa Medicaid Provider Services Unit. Manual claims shall be directed to the Iowa Medicaid/Provider Services Unit.

The FMS is responsible to process and pay invoices for approved goods and services included in the CCO participant's written individual budgets, maintain documentation and monitor that payments are reflected in the consumer's written individual budget. ". All support employees that a CCO participant hires must complete time cards and submit them to the FMS in order to be paid for services. All other goods and services purchased that are listed in the member's CCO budget must be submitted to the FMS with a receipt or invoice in order for payment to be made

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 state Medicaid identification number is required on all claim forms.

Iowa Medicaid 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. 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.

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.)

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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.)

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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 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 Iowa Medicaid 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 Iowa Medicaid 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.

For the Consumer Choice's Option, the FMS is responsible to 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. The FMS is responsible for monitoring 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 and provide to the department an annual independent audit of the financial management service.

As described in I-1, EVV is currently only applicable to PCS 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. 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, T1002-IMMT HHA RN Services 15 Minutes, T1003-IMMT HHA LPN/LVN Services Up To 15 Minutes, and T1004-IMMT SCL 15 Minutes.

Prevention of member coercion:

The case managers, IHH care coordinators, and MCO CCBCMs 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. A specific survey question relates to the members' ability to choose their providers. Any indication coercion will result in followup action by the HCBS staff.

Iowa Medicaid HCBS Unit observes a random sample of interdisciplinary team (IDT) meetings conducted by MCO Community Based Managers. This allows the HCBS Unit to note any member coercion in choice of providers. HCBS staff then requests the final service plan to ensure that the final plan does include the services, units and providers chosen by the member. Any changes and omissions require followup by the HCBS staff for resolution by the MCO.

As part of the EQR process, the contractor performs onsite reviews of the MCOs that include processes that impact BI Waiver providers and members. Reviews include credentialing files, critical processes such as service authorization validation, claims processing, training and care coordination.

- 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, and shall be processed by the Iowa Medicaid Provider Services Unit. Manual claims shall be directed to the Iowa Medicaid 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.

For CCO enrollees the Financial Management Service (FMS) provider receives Medicaid funds on behalf of the member based on the member's approved monthly budget. 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.*

Iowa Medicaid 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. 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 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: <http://hhs.iowa.gov/policy-manuals/medicaid-provider>.

Capitation payments to MCOs are made by the MMIS. The MMIS has recipient eligibility and MCO assignment information. When a recipient is enrolled in an MCO, this is reflected on his/her eligibility file and monthly payment flows from the MMIS to the MCO via an 837 transaction. A monthly payment to the MCO on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

The claim details submitted for payment is reviewed and reconciled by Iowa Medicaid 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: <http://hhs.iowa.gov/policy-manuals/mcicaid-provider>.

Providers through the Consumer Choices Option (CCO) program are issued instructions on billing through the FMS. Iowa Medicaid identifies the Financial Management Service (FMS) provider as the limited fiscal agent. MMIS will not allow payment for services authorized through CCO. The state's fiscal agent is Veridian Fiscal Solutions for the Consumer Choices Option. Veridian Fiscal Solutions is an enrolled Medicaid waiver FMS provider.

Payment for services by the FMS include attendant care (unskilled), adult day care, HVM, medical day care for children, prevocational services, individual respite, specialized medical equipment, SCL, SE, and transportation services.

The FMS shall perform all of the following functions:

- (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."*
- This information is included in the amendment in Appendix E-I-a.*

For MCO enrollees, for the self-direction option of the waivers, payments will be made to a financial management service, which will be designated by the state as an organized healthcare delivery system to make payments to the entities providing support and goods for members that self-direct. The financial management service must meet provider qualifications established by the state and pass a readiness review approved by the state and be enrolled as a Medicaid provider with the state. The state will also oversee the operations of the financial management service by provide periodical audits.

Iowa Medicaid exercises oversight of the fiscal agent through both the IoWANS system and through our 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.

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.

N/A

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 Brain Injury waiver. They provide Supported Community Living, Supported Employment and Respite services.

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 Iowa Medicaid 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 BI 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 Iowa Medicaid 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 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 section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 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 text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 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 section 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. It states 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. That 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 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:

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Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

--

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility, 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	35069.97	10849.06	45919.03	61760.11	3398.98	65159.09	19240.06
2	36089.44	11174.53	47263.97	63612.91	3500.95	67113.86	19849.89
3	37130.43	11509.77	48640.20	65521.30	3605.98	69127.28	20487.08
4	38195.75	11855.06	50050.81	67486.94	3714.16	71201.10	21150.29
5	39283.76	12210.71	51494.47	69511.55	3825.59	73337.14	21842.67

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:	Level of Care:
		Nursing Facility	ICF/IID
Year 1	1747	1691	56

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:	Level of Care:
		Nursing Facility	ICF/IID
Year 2	1747	1691	56
Year 3	1747	1691	56
Year 4	1747	1691	56
Year 5	1747	1691	56

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 Brain Injury (BI) 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 BI waiver 372 reports submitted in December 2023 and December 2024.

Unduplicated participants in the current BI 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 1,747 (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 BI 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 October 1, 2021 – September 30, 2023 (submitted March 2023 and March 2024).*
- The factor estimates are from the actuarial report 'Factor Estimate Summary for HCBS Populations' calculated 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 1,747 (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.

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 Brain Injury (BI) 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 October 1, 2021 – September 30, 2023. This data is or will be the basis for the BI 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.

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-I. 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. In the current estimate, Factor G' on the actuarial report and in WY1 is less than Factor D'.

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 \$10,849, 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 and for WY1 is \$61,760.

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 \$3,399.

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. In the current estimate, Factor G' on the actuarial report and in WY1 is less than Factor D'.

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	
Case Management	
Prevocational Services	
Respite	
Supported Employment	
Specialized Medical Equipment	
Financial Management Service	
Independent Support Broker	
Individual Directed Goods and Services	
Attendant Care	
Enabling Technology for Remote Support	
Family Training Services	
Home and Vehicle Modification	
Interim Medical Monitoring and Treatment (IMMT)	
Medical Day Care for Children	
Personal Emergency Response System or Portable Locator System	
Positive Behavioral Support and Consultation	
Skilled Attendant Care	
Supported Community Living	

Waiver Services	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							387625.55
Adult Day Care - Extended Day		Extended Day	4	45.57	115.57	21066.10	
Adult Day Care - 15 Minutes		15 Minutes	1	313.86	7.23	2269.21	
Adult Day Care - Half Day		Half Day	33	13.33	65.84	28962.36	
Adult Day Care - Full Day		Full Day	100	31.73	102.01	323677.73	
FFS Adult Day Care - Extended Day		Extended Day	1	45.57	115.57	5266.52	
FFS Adult Day Care - 15 minutes		15 Minutes	1	313.86	7.23	2269.21	
FFS Adult Day Care - Half Day		Half Day	1	13.33	65.84	877.65	
FFS Adult Day Care - Full Day		Full Day	1	31.73	102.01	3236.78	
Case Management Total:							1270888.72
Case Management 15 minutes		15 Minutes	10	122.06	68.50	83611.10	
FFS Case Management 15 minutes		15 Minutes	142	122.06	68.50	1187277.62	
<p style="text-align: right;">GRAND TOTAL: 61267244.47</p> <p style="text-align: right;">Total: Services included in capitation: 55593520.65</p> <p style="text-align: right;">Total: Services not included in capitation: 5673723.82</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 35069.97</p> <p style="text-align: right;">Services included in capitation: 31822.28</p> <p style="text-align: right;">Services not included in capitation: 3247.70</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:							58018.75
Prevocational Services, Hour		Hour	8	361.15	10.71	30943.33	
Prevocational Services, Career Exploration, Hour		Hour	4	361.15	10.71	15471.67	
FFS Prevocational services, Hour		Hour	2	361.15	10.71	7735.83	
FFS Prevocational Services, Career Exploration, Hour		Hour	1	361.15	10.71	3867.92	
Respite Total:							4074595.11
Respite - HHA Specialized		15 Minutes	10	3178.95	3.44	109355.88	
Respite - Child Care		15 Minutes	2	794.14	2.71	4304.24	
Respite - Home Care Agcy & Non-Facility, Group		15 Minutes	65	1908.95	2.49	308963.56	
Respite - Resident Camp - Weeklong		15 Minutes	2	455.27	1.96	1784.66	
Respite - Teen Day Camp - 13 to 21 years old		15 Minutes	1	1072.85	3.98	4269.94	
Respite - Group Specialized Summer Day Camp		15 Minutes	7	646.08	2.49	11261.17	
Respite - HHA Basic Individual		15 Minutes	70	2078.39	2.93	426277.79	
Respite - Home Care Agcy & Non-Facility, Basic Individual		15 Minutes	284	2608.08	3.29	2436885.63	
Respite - Camp		15 Minutes	1	15.84	2.50	39.60	
Respite - Weekend On-Site Respite -		15 Minutes	2	2787.02	2.61	14548.24	
<p style="text-align: right;">GRAND TOTAL: 61267244.47</p> <p style="text-align: right;">Total: Services included in capitation: 55593520.65</p> <p style="text-align: right;">Total: Services not included in capitation: 5673723.82</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 35069.97</p> <p style="text-align: right;">Services included in capitation: 31822.28</p> <p style="text-align: right;">Services not included in capitation: 3247.70</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Camp							
Respite - hospital or nursing facility/skilled		15 Minutes	1	2185.28	2.70	5900.26	
Respite - Home Care Agcy & Non-Facility, Specialized		15 Minutes	9	316.71	34.55	98480.97	
Respite - Foster Group Care		15 Minutes	1	7.92	2.73	21.62	
Respite - RCF		15 Minutes	1	3800.49	2.55	9691.25	
Respite - Adult Day Care		15 Minutes	1	197.94	5.08	1005.54	
Respite - ICF/ID		15 Minutes	1	3800.49	2.55	9691.25	
FFS Respite - HHA Specialized		15 Minutes	2	3178.95	3.44	21871.18	
FFS Respite - Child Care		15 Minutes	1	794.14	2.71	2152.12	
FFS Respite - Home Care Agcy & Non-Facility, Group		15 Minutes	11	1908.95	2.49	52286.14	
FFS Respite - Resident Camp - Weeklong		15 Minutes	1	455.27	1.96	892.33	
FFS Respite - Teen Day Camp - 13 to 21 years old		15 Minutes	1	1072.85	3.98	4269.94	
FFS Respite - Group Specialized Summer Day Camp		15 Minutes	1	646.08	2.49	1608.74	
FFS Respite - HHA Basic Individual		15 Minutes	12	2078.39	2.93	73076.19	
FFS Respite - Home Care Agcy & Non-Facility, Basic Individual		15 Minutes	49	2608.08	3.29	420448.58	
FFS Respite - Camp		15 Minutes	1	15.84	2.50	39.60	
FFS Respite -						7274.12	
<p style="text-align: right;">GRAND TOTAL: 61267244.47</p> <p style="text-align: right;">Total: Services included in capitation: 55593520.65</p> <p style="text-align: right;">Total: Services not included in capitation: 5673723.82</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 35069.97</p> <p style="text-align: right;">Services included in capitation: 31822.28</p> <p style="text-align: right;">Services not included in capitation: 3247.70</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Weekend On-Site Respite - Camp		15 Minutes	1	2787.02	2.61		
FFS Respite - hospital or nursing facility/skilled		15 Minutes	1	2185.28	2.70	5900.26	
FFS Respite - Home Care Agcy & Non-Facility, Specialized		15 Minutes	2	316.71	34.55	21884.66	
FFS Respite - Foster Group Care		15 Minutes	1	7.92	2.73	21.62	
FFS Respite - RCF		15 Minutes	1	3800.49	2.55	9691.25	
FFS Respite - Adult Day Care		15 Minutes	1	197.94	5.08	1005.54	
FFS Respite - ICF/ID		15 Minutes	1	3800.49	2.55	9691.25	
Supported Employment Total:							80914.84
Individual Supported Employment Hour		Hour	33	3.53	327.25	38121.35	
Small Group Supported Employment 15 Minutes		15 Minutes	14	599.26	1.12	9396.40	
Long Term Job Coaching - Monthly		Month	58	9.27	39.55	21264.45	
Long Term Job Coaching - Hour		Hour	8	17.63	38.84	5477.99	
FFS Individual Supported Employment Hour		Hour	3	3.53	327.25	3465.58	
FFS Small Group Supported Employment 15 Minutes		15 Minutes	1	599.26	1.12	671.17	
FFS Long Term Job Coaching - Monthly		Month	5	9.27	39.55	1833.14	
FFS Long Term Job		Hour	1	17.63	38.84	684.75	
<p style="text-align: right;">GRAND TOTAL: 61267244.47</p> <p style="text-align: right;">Total: Services included in capitation: 55593520.65</p> <p style="text-align: right;">Total: Services not included in capitation: 5673723.82</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 35069.97</p> <p style="text-align: right;">Services included in capitation: 31822.28</p> <p style="text-align: right;">Services not included in capitation: 3247.70</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coaching - Hour							
Specialized Medical Equipment Total:							23995.67
Specialized Medical Equipment		Occurrence	7	49.00	14.35	4922.05	
FFS Specialized Medical Equipment		Occurrence	6	1.08	2943.46	19073.62	
Financial Management Service Total:							393889.29
Financial Management Service		Month	423	10.31	71.19	310468.84	
FFS Financial Management Service		Month	105	11.16	71.19	83420.44	
Independent Support Broker Total:							44775.21
Independent Support Broker		Month	360	9.27	5.92	19756.22	
FFS Independent Support Broker		Month	98	9.27	27.54	25018.99	
Individual Directed Goods and Services Total:							108838.51
Individual Directed Goods and Services		Month	398	9.27	27.53	101570.83	
FFS Individual Directed Goods and Services		Month	50	9.27	15.68	7267.68	
Attendant Care Total:							935407.37
Attendant Care Agency		15 Minutes	156	831.03	5.60	725987.81	
FFS Attendant Care Agency		15 Minutes	45	831.03	5.60	209419.56	
Enabling Technology for Remote Support Total:							167016.72
<p style="text-align: right;">GRAND TOTAL: 61267244.47</p> <p style="text-align: right;">Total: Services included in capitation: 55593520.65</p> <p style="text-align: right;">Total: Services not included in capitation: 5673723.82</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 35069.97</p> <p style="text-align: right;">Services included in capitation: 31822.28</p> <p style="text-align: right;">Services not included in capitation: 3247.70</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
1 Job (equipment/ technology)		1 Job	25	238.80	13.45	80296.50	
1 Assessment		1 Assessment	25	238.80	13.45	80296.50	
FFS 1 Job (equipment/ technology)		1 Job	1	238.80	13.45	3211.86	
FFS 1 Assessment		1 Assessment	1	238.80	13.45	3211.86	
Family Training Services Total:							83508.36
Family Counseling and Training Services		15 Minutes	25	238.80	13.45	80296.50	
FFS Family Counseling and Training Services		15 Minutes	1	238.80	13.45	3211.86	
Home and Vehicle Modification Total:							355320.11
Home and Vehicle Modification		Occurrence	51	1.10	5023.58	281822.84	
FFS Home and Vehicle Modification		Occurrence	7	1.10	9545.10	73497.27	
Interim Medical Monitoring and Treatment (IMMT) Total:							374766.56
IMMT, HHA		15 Minutes	1	935.70	10.54	9862.28	
IMMT, RN		15 Minutes	5	935.70	10.54	49311.39	
FFS IMMT, HHA		15 Minutes	6	935.70	10.54	59173.67	
FFS IMMT, RN		15 Minutes	26	935.70	10.54	256419.23	
Medical Day Care for Children Total:							1723680.00
Medical Day Care for Children		15 Minutes	24	5600.00	8.55	1149120.00	
FFS Medical Day Care for Children		15 Minutes	12	5600.00	8.55	574560.00	
Personal							147079.64
<p style="text-align: right;">GRAND TOTAL: 61267244.47</p> <p style="text-align: right;">Total: Services included in capitation: 55593520.65</p> <p style="text-align: right;">Total: Services not included in capitation: 5673723.82</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 35069.97</p> <p style="text-align: right;">Services included in capitation: 31822.28</p> <p style="text-align: right;">Services not included in capitation: 3247.70</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Response System or Portable Locator System Total:							
Personal Emergency Response - Initial		Installation	23	1.00	1036.40	23837.20	
Personal Emergency Response - Ongoing		Month	346	9.27	37.24	119444.32	
FFS Personal Emergency Response - Initial		Installation	1	1.00	1036.40	1036.40	
FFS Personal Emergency Response - Ongoing		Month	8	9.27	37.24	2761.72	
Positive Behavioral Support and Consultation Total:							1548.00
Behavioral Programming		15 Minutes	9	12.00	12.90	1393.20	
FFS Behavioral Programming		15 Minutes	1	12.00	12.90	154.80	
Skilled Attendant Care Total:							102382.90
Attendant Care Agency		15 Minutes	17	831.03	5.60	79114.06	
FFS Attendant Care Agency		15 Minutes	5	831.03	5.60	23268.84	
Supported Community Living Total:							48721055.17
Supported Community Living - 15 Minutes		15 Minutes	279	982.78	33.15	9089584.80	
Supported Community Living - Daily		Day	130	254.73	1142.04	37818540.40	
FFS Supported Community Living - 15 Minutes		15 Minutes	11	982.78	33.15	358370.73	
FFS Supported Community Living - Daily		Day	5	254.73	1142.04	1454559.25	
<p style="text-align: right;">GRAND TOTAL: 61267244.47</p> <p style="text-align: right;">Total: Services included in capitation: 55593520.65</p> <p style="text-align: right;">Total: Services not included in capitation: 5673723.82</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 35069.97</p> <p style="text-align: right;">Services included in capitation: 31822.28</p> <p style="text-align: right;">Services not included in capitation: 3247.70</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Living - Daily							
Transportation Total:							2211937.99
Transportation - Mile		Mile	158	381.17	8.40	505888.82	
Transportation - Trip		Trip	136	205.31	37.22	1039262.80	
FFS Transportation - Mile		Mile	3	381.17	8.40	9605.48	
FFS Transportation - Trip		Trip	86	205.31	37.22	657180.89	
<p style="text-align: right;">GRAND TOTAL: 61267244.47</p> <p style="text-align: right;">Total: Services included in capitation: 55593520.65</p> <p style="text-align: right;">Total: Services not included in capitation: 5673723.82</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 35069.97</p> <p style="text-align: right;">Services included in capitation: 31822.28</p> <p style="text-align: right;">Services not included in capitation: 3247.70</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							400011.35
Adult Day Care - Extended Day		Extended Day	4	45.57	117.30	21381.44	
Adult Day Care - 15 Minutes		15 Minutes	1	313.86	7.34	2303.73	
Adult Day Care - Half Day		Half Day	33	13.33	66.83	29397.85	
<p style="text-align: right;">GRAND TOTAL: 63048256.69</p> <p style="text-align: right;">Total: Services included in capitation: 57249080.39</p> <p style="text-align: right;">Total: Services not included in capitation: 5799176.30</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 36089.44</p> <p style="text-align: right;">Services included in capitation: 32769.94</p> <p style="text-align: right;">Services not included in capitation: 3319.51</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care - Full Day		Full Day	102	31.73	103.54	335103.07	
FFS Adult Day Care - Extended Day		Extended Day	1	45.57	117.30	5345.36	
FFS Adult Day Care - 15 minutes		15 minutes	1	313.86	7.34	2303.73	
FFS Adult Day Care - Half Day		Half day	1	13.33	66.83	890.84	
FFS Adult Day Care - Full Day		Full Day	1	31.73	103.54	3285.32	
Case Management Total:							1306972.10
Case Management 15 minutes		15 Minutes	10	122.06	69.53	84868.32	
FFS Case Management 15 minutes		15 Minutes	144	122.06	69.53	1222103.78	
Prevocational Services Total:							58885.51
Prevocational Services, Hour		Hour	8	361.15	10.87	31405.60	
Prevocational Services, Career Exploration, Hour		Hour	4	361.15	10.87	15702.80	
FFS Prevocational services, Hour		Hour	2	361.15	10.87	7851.40	
FFS Prevocational Services, Career Exploration, Hour		Hour	1	361.15	10.87	3925.70	
Respite Total:							4190538.99
Respite - HHA Specialized		15 Minutes	10	3178.95	3.49	110945.36	
Respite - Child Care		15 Minutes	2	794.14	2.75	4367.77	
Respite - Home Care Agency & Non-Facility, Group		15 Minutes	66	1908.95	2.53	318756.47	
Respite -						1811.97	
<p style="text-align: right;">GRAND TOTAL: 63048256.69</p> <p style="text-align: right;">Total: Services included in capitation: 57249080.39</p> <p style="text-align: right;">Total: Services not included in capitation: 5799176.30</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 36089.44</p> <p style="text-align: right;">Services included in capitation: 32769.94</p> <p style="text-align: right;">Services not included in capitation: 3319.51</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Resident Camp - Weeklong		15 Minutes	2	455.27	1.99		
Respite - Teen Day Camp - 13 to 21 years old		15 Minutes	1	1072.85	4.04	4334.31	
Respite - Group Specialized Summer Day Camp		15 Minutes	7	646.08	2.53	11442.08	
Respite - HHA Basic Individual		15 Minutes	71	2078.39	2.97	438270.10	
Respite - Home Care Agcy & Non-Facility, Basic Individual		15 Minutes	288	2608.08	3.34	2508764.31	
Respite - Camp		15 Minutes	1	15.84	2.54	40.23	
Respite - Weekend On-Site Respite - Camp		15 Minutes	2	2787.02	2.65	14771.21	
Respite - hospital or nursing facility/skilled		15 Minutes	1	2185.28	2.74	5987.67	
Respite - Home Care Agcy & Non-Facility, Specialized		15 Minutes	9	316.71	35.07	99963.18	
Respite - Foster Group Care		15 Minutes	1	7.92	2.77	21.94	
Respite - RCF		15 Minutes	1	3800.49	2.59	9843.27	
Respite - Adult Day Care		15 Minutes	1	197.94	5.16	1021.37	
Respite - ICF/ID		15 Minutes	1	3800.49	2.59	9843.27	
FFS Respite - HHA Specialized		15 Minutes	2	3178.95	3.49	22189.07	
FFS Respite - Child Care		15 Minutes	1	794.14	2.75	2183.88	
FFS Respite - Home Care Agcy & Non-Facility, Group		15 Minutes	11	1908.95	2.53	53126.08	
<p style="text-align: right;">GRAND TOTAL: 63048256.69</p> <p style="text-align: right;">Total: Services included in capitation: 57249080.39</p> <p style="text-align: right;">Total: Services not included in capitation: 5799176.30</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 36089.44</p> <p style="text-align: right;">Services included in capitation: 32769.94</p> <p style="text-align: right;">Services not included in capitation: 3319.51</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS Respite - Resident Camp - Weeklong		15 Minutes	1	455.27	1.99	905.99	
FFS Respite - Teen Day Camp - 13 to 21 years old		15 Minutes	1	1072.85	4.04	4334.31	
FFS Respite - Group Specialized Summer Day Camp		15 Minutes	1	646.08	2.53	1634.58	
FFS Respite - HHA Basic Individual		15 Minutes	12	2078.39	2.97	74073.82	
FFS Respite - Home Care Agcy & Non-Facility, Basic Individual		15 Minutes	50	2608.08	3.34	435549.36	
FFS Respite - Camp		15 Minutes	1	15.84	2.54	40.23	
FFS Respite - Weekend On-Site Respite - Camp		15 Minutes	1	2787.02	2.65	7385.60	
FFS Respite - hospital or nursing facility/skilled		15 Minutes	1	2185.28	2.74	5987.67	
FFS Respite - Home Care Agcy & Non-Facility, Specialized		15 Minutes	2	316.71	35.07	22214.04	
FFS Respite - Foster Group Care		15 Minutes	1	7.92	2.77	21.94	
FFS Respite - RCF		15 Minutes	1	3800.49	2.59	9843.27	
FFS Respite - Adult Day Care		15 Minutes	1	197.94	5.16	1021.37	
FFS Respite - ICF/ID		15 Minutes	1	3800.49	2.59	9843.27	
Supported Employment Total:							82527.27
Individual Supported Employment Hour		Hour	33	3.53	332.16	38693.32	
Small Group Supported						9564.19	
<p style="text-align: right;">GRAND TOTAL: 63048256.69</p> <p style="text-align: right;">Total: Services included in capitation: 57249080.39</p> <p style="text-align: right;">Total: Services not included in capitation: 5799176.30</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 36089.44</p> <p style="text-align: right;">Services included in capitation: 32769.94</p> <p style="text-align: right;">Services not included in capitation: 3319.51</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment 15 Minutes		15 Minutes	14	599.26	1.14		
Long Term Job Coaching - Monthly		Month	59	9.27	40.14	21953.77	
Long Term Job Coaching - Hour		Hour	8	17.63	39.42	5559.80	
FFS Individual Supported Employment Hour		Hour	3	3.53	332.16	3517.57	
FFS Small Group Supported Employment 15 Minutes		15 Minutes	1	599.26	1.14	683.16	
FFS Long Term Job Coaching - Monthly		Month	5	9.27	40.14	1860.49	
FFS Long Term Job Coaching - Hour		Hour	1	17.63	39.42	694.97	
Specialized Medical Equipment Total:							24357.22
Specialized Medical Equipment		Occurrence	7	49.00	14.57	4997.51	
FFS Specialized Medical Equipment		Occurrence	6	1.08	2987.61	19359.71	
Financial Management Service Total:							405892.37
Financial Management Service		Month	429	10.31	72.26	319605.26	
FFS Financial Management Service		Month	107	11.16	72.26	86287.11	
Independent Support Broker Total:							45985.69
Indepedent Support Broker		Month	365	9.27	6.01	20335.14	
FFS Independent Support Broker		Month	99	9.27	27.95	25650.55	
<p style="text-align: right;">GRAND TOTAL: 63048256.69</p> <p style="text-align: right;">Total: Services included in capitation: 57249080.39</p> <p style="text-align: right;">Total: Services not included in capitation: 5799176.30</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 36089.44</p> <p style="text-align: right;">Services included in capitation: 32769.94</p> <p style="text-align: right;">Services not included in capitation: 3319.51</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Directed Goods and Services Total:							112164.03
Individual Directed Goods and Services		Month	404	9.27	27.94	104637.54	
FFS Individual Directed Goods and Services		Month	51	9.27	15.92	7526.50	
Attendant Care Total:							962931.08
Attendant Care Agency		15 Minutes	158	831.03	5.68	745799.56	
FFS Attendant Care Agency		15 Minutes	46	831.03	5.68	217131.52	
Enabling Technology for Remote Support Total:							169500.24
1 Job (equipment/ technology)		1 Job	25	238.80	13.65	81490.50	
1 Assessment		1 Assessment	25	238.80	13.65	81490.50	
FFS 1 Job (equipment/ technology)		1 Job	1	238.80	13.65	3259.62	
FFS 1 Assessment		1 Assessment	1	238.80	13.65	3259.62	
Family Training Services Total:							84750.12
Family Counseling and Training Services		15 Minutes	25	238.80	13.65	81490.50	
FFS Family Counseling and Training Services		15 Minutes	1	238.80	13.65	3259.62	
Home and Vehicle Modification Total:							366258.55
Home and Vehicle Modification		Occurrence	52	1.10	5098.93	291658.80	
FFS Home and Vehicle Modification		Occurrence	7	1.10	9688.28	74599.76	
<p style="text-align: right;">GRAND TOTAL: 63048256.69</p> <p style="text-align: right;">Total: Services included in capitation: 57249080.39</p> <p style="text-align: right;">Total: Services not included in capitation: 5799176.30</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 36089.44</p> <p style="text-align: right;">Services included in capitation: 32769.94</p> <p style="text-align: right;">Services not included in capitation: 3319.51</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Interim Medical Monitoring and Treatment (IMMT) Total:							380455.62
IMMT, HHA		15 Minutes	1	935.70	10.70	10011.99	
IMMT, RN		15 Minutes	5	935.70	10.70	50059.95	
FFS IMMT, HHA		15 Minutes	6	935.70	10.70	60071.94	
FFS IMMT, RN		15 Minutes	26	935.70	10.70	260311.74	
Medical Day Care for Children Total:							1749888.00
Medical Day Care for Children		15 Minutes	24	5600.00	8.68	1166592.00	
FFS Medical Day Care for Children		15 Minutes	12	5600.00	8.68	583296.00	
Personal Emergency Response System or Portable Locator System Total:							151042.55
Personal Emergency Response - Initial		Installation	23	1.00	1051.95	24194.85	
Personal Emergency Response - Ongoing		Month	351	9.27	37.80	122992.51	
FFS Personal Emergency Response - Initial		Installation	1	1.00	1051.95	1051.95	
FFS Personal Emergency Response - Ongoing		Month	8	9.27	37.80	2803.25	
Positive Behavioral Support and Consultation Total:							1570.80
Behavioral Programming		15 Minutes	9	12.00	13.09	1413.72	
FFS Behavioral Programming		15 Minutes	1	12.00	13.09	157.08	
<p style="text-align: right;">GRAND TOTAL: 63048256.69</p> <p style="text-align: right;">Total: Services included in capitation: 57249080.39</p> <p style="text-align: right;">Total: Services not included in capitation: 5799176.30</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 36089.44</p> <p style="text-align: right;">Services included in capitation: 32769.94</p> <p style="text-align: right;">Services not included in capitation: 3319.51</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled Attendant Care Total:							103845.51
Attendant Care Agency		15 Minutes	17	831.03	5.68	80244.26	
FFS Attendant Care Agency		15 Minutes	5	831.03	5.68	23601.25	
Supported Community Living Total:							50175467.07
Supported Community Living - 15 Minutes		15 Minutes	283	982.78	33.65	9358964.80	
Supported Community Living - Daily		Day	132	254.73	1159.17	38976349.38	
FFS Supported Community Living - 15 Minutes		15 Minutes	11	982.78	33.65	363776.02	
FFS Supported Community Living - Daily		Day	5	254.73	1159.17	1476376.87	
Transportation Total:							2275212.61
Transportation - Mile		Mile	160	381.17	8.53	520220.82	
Transportation - Trip		Trip	138	205.31	37.78	1070412.43	
FFS Transportation - Mile		Mile	3	381.17	8.53	9754.14	
FFS Transportation - Trip		Trip	87	205.31	37.78	674825.23	
<p style="text-align: right;">GRAND TOTAL: 63048256.69</p> <p style="text-align: right;">Total: Services included in capitation: 57249080.39</p> <p style="text-align: right;">Total: Services not included in capitation: 5799176.30</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 36089.44</p> <p style="text-align: right;">Services included in capitation: 32769.94</p> <p style="text-align: right;">Services not included in capitation: 3319.51</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. **Concurrent section 1915(b)/section 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

08/15/2025

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							412669.35
Adult Day Care - Extended Day		Extended Day	4	45.57	119.06	21702.26	
Adult Day Care - 15 Minutes		15 Minutes	1	313.86	7.45	2338.26	
Adult Day Care - Half Day		Half Day	33	13.33	67.83	29837.74	
Adult Day Care - Full Day		Full Day	104	31.73	105.09	346788.59	
FFS Adult Day Care - Extended Day		Extended Day	1	45.57	119.06	5425.56	
FFS Adult Day Care - 15 minutes		15 Minutes	1	313.86	7.45	2338.26	
FFS Adult Day Care - Half Day		Half Day	1	13.33	67.83	904.17	
FFS Adult Day Care - Full Day		Full Day	1	31.73	105.09	3334.51	
Case Management Total:							1343748.78
Case Management 15 minutes		15 Minutes	10	122.06	70.57	86137.74	
FFS Case Management 15 minutes		15 Minutes	146	122.06	70.57	1257611.03	
Prevocational Services Total:							59752.27
Prevocational Services, Hour		Hour	8	361.15	11.03	31867.88	
Prevocational Services, Career Exploration, Hour		Hour	4	361.15	11.03	15933.94	
FFS Prevocational services, Hour		Hour	2	361.15	11.03	7966.97	
FFS Prevocational Services, Career Exploration, Hour		Hour	1	361.15	11.03	3983.48	
Respite Total:							4308140.74
<p style="text-align: right;">GRAND TOTAL: 64866864.21</p> <p style="text-align: right;">Total: Services included in capitation: 58939873.71</p> <p style="text-align: right;">Total: Services not included in capitation: 5926990.50</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 37130.43</p> <p style="text-align: right;">Services included in capitation: 33737.76</p> <p style="text-align: right;">Services not included in capitation: 3392.67</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite - HHA Specialized		15 Minutes	10	3178.95	3.54	112534.83	
Respite - Child Care		15 Minutes	2	794.14	2.79	4431.30	
Respite - Home Care Agcy & Non-Facility, Group		15 Minutes	67	1908.95	2.57	328702.10	
Respite - Resident Camp - Weeklong		15 Minutes	2	455.27	2.02	1839.29	
Respite - Teen Day Camp - 13 to 21 years old		15 Minutes	1	1072.85	4.10	4398.68	
Respite - Group Specialized Summer Day Camp		15 Minutes	7	646.08	2.57	11622.98	
Respite - HHA Basic Individual		15 Minutes	72	2078.39	3.01	450428.68	
Respite - Home Care Agcy & Non-Facility, Basic Individual		15 Minutes	292	2608.08	3.39	2581686.23	
Respite - Camp		15 Minutes	1	15.84	2.58	40.87	
Respite - Weekend On-Site Respite - Camp		15 Minutes	2	2787.02	2.69	14994.17	
Respite - hospital or nursing facility/skilled		15 Minutes	1	2185.28	2.78	6075.08	
Respite - Home Care Agcy & Non-Facility, Specialized		15 Minutes	9	316.71	35.60	101473.88	
Respite - Foster Group Care		15 Minutes	1	7.92	2.81	22.26	
Respite - RCF		15 Minutes	1	3800.49	2.63	9995.29	
Respite - Adult Day Care		15 Minutes	1	197.94	5.24	1037.21	
Respite - ICF/ID		15 Minutes				9995.29	
<p style="text-align: right;">GRAND TOTAL: 64866864.21</p> <p style="text-align: right;">Total: Services included in capitation: 58939873.71</p> <p style="text-align: right;">Total: Services not included in capitation: 5926990.50</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 37130.43</p> <p style="text-align: right;">Services included in capitation: 33737.76</p> <p style="text-align: right;">Services not included in capitation: 3392.67</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			1	3800.49	2.63		
FFS Respite - HHA Specialized		15 Minutes	2	3178.95	3.54	22506.97	
FFS Respite - Child Care		15 Minutes	1	794.14	2.79	2215.65	
FFS Respite - Home Care Agcy & Non- Facility, Group		15 Minutes	11	1908.95	2.57	53966.02	
FFS Respite - Resident Camp - Weeklong		15 Minutes	1	455.27	2.02	919.65	
FFS Respite - Teen Day Camp - 13 to 21 years old		15 Minutes	1	1072.85	4.10	4398.68	
FFS Respite - Group Specialized Summer Day Camp		15 Minutes	1	646.08	2.57	1660.43	
FFS Respite - HHA Basic Individual		15 Minutes	12	2078.39	3.01	75071.45	
FFS Respite - Home Care Agcy & Non- Facility, Basic Individual		15 Minutes	51	2608.08	3.39	450910.95	
FFS Respite - Camp		15 Minutes	1	15.84	2.58	40.87	
FFS Respite - Weekend On- Site Respite - Camp		15 Minutes	1	2787.02	2.69	7497.08	
FFS Respite - hospital or nursing facility/skilled		15 Minutes	1	2185.28	2.78	6075.08	
FFS Respite - Home Care Agcy & Non- Facility, Specialized		15 Minutes	2	316.71	35.60	22549.75	
FFS Respite - Foster Group Care		15 Minutes	1	7.92	2.81	22.26	
FFS Respite - RCF		15 Minutes	1	3800.49	2.63	9995.29	
FFS Respite - Adult Day		15 Minutes				1037.21	
<p style="text-align: right;">GRAND TOTAL: 64866864.21</p> <p style="text-align: right;">Total: Services included in capitation: 58939873.71</p> <p style="text-align: right;">Total: Services not included in capitation: 5926990.50</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 37130.43</p> <p style="text-align: right;">Services included in capitation: 33737.76</p> <p style="text-align: right;">Services not included in capitation: 3392.67</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care			1	197.94	5.24		
FFS Respite - ICF/ID		15 Minutes	1	3800.49	2.63	9995.29	
Supported Employment Total:							84167.15
Individual Supported Employment Hour		Hour	33	3.53	337.14	39273.44	
Small Group Supported Employment 15 Minutes		15 Minutes	14	599.26	1.16	9731.98	
Long Term Job Coaching - Monthly		Month	60	9.27	40.74	22659.59	
Long Term Job Coaching - Hour		Hour	8	17.63	40.01	5643.01	
FFS Individual Supported Employment Hour		Hour	3	3.53	337.14	3570.31	
FFS Small Group Supported Employment 15 Minutes		15 Minutes	1	599.26	1.16	695.14	
FFS Long Term Job Coaching - Monthly		Month	5	9.27	40.74	1888.30	
FFS Long Term Job Coaching - Hour		Hour	1	17.63	40.01	705.38	
Specialized Medical Equipment Total:							24723.05
Specialized Medical Equipment		Occurrence	7	49.00	14.79	5072.97	
FFS Specialized Medical Equipment		Occurrence	6	1.08	3032.42	19650.08	
Financial Management Service Total:							418132.61
Financial Management Service		Month	435	10.31	73.34	328918.90	
<p style="text-align: right;">GRAND TOTAL: 64866864.21</p> <p style="text-align: right;">Total: Services included in capitation: 58939873.71</p> <p style="text-align: right;">Total: Services not included in capitation: 5926990.50</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 37130.43</p> <p style="text-align: right;">Services included in capitation: 33737.76</p> <p style="text-align: right;">Services not included in capitation: 3392.67</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS Financial Management Service		Month	109	11.16	73.34	89213.71	
Independent Support Broker Total:							47221.38
Independent Support Broker		Month	370	9.27	6.10	20922.39	
FFS Independent Support Broker		Month	100	9.27	28.37	26298.99	
Individual Directed Goods and Services Total:							115577.62
Individual Directed Goods and Services		Month	410	9.27	28.36	107787.85	
FFS Individual Directed Goods and Services		Month	52	9.27	16.16	7789.77	
Attendant Care Total:							992573.92
Attendant Care Agency		15 Minutes	160	831.03	5.77	767206.90	
FFS Attendant Care Agency		15 Minutes	47	831.03	5.77	225367.03	
Enabling Technology for Remote Support Total:							171983.76
1 Job (equipment/ technology)		1 Job	25	238.80	13.85	82684.50	
1 Assessment		1 Assessment	25	238.80	13.85	82684.50	
FFS 1 Job (equipment/ technology)		1 Job	1	238.80	13.85	3307.38	
FFS 1 Assessment		1 Assessment	1	238.80	13.85	3307.38	
Family Training Services Total:							85991.88
Family Counseling and Training Services		15 Minutes	25	238.80	13.85	82684.50	
FFS Family						3307.38	
<p align="center">GRAND TOTAL: 64866864.21</p> <p align="center">Total: Services included in capitation: 58939873.71</p> <p align="center">Total: Services not included in capitation: 5926990.50</p> <p align="center">Total Estimated Unduplicated Participants: 1747</p> <p align="center">Factor D (Divide total by number of participants): 37130.43</p> <p align="center">Services included in capitation: 33737.76</p> <p align="center">Services not included in capitation: 3392.67</p> <p align="center">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Counseling and Training Services		15 Minutes	1	238.80	13.85		
Home and Vehicle Modification Total:							377445.12
Home and Vehicle Modification		Occurrence	53	1.10	5175.41	301726.40	
FFS Home and Vehicle Modification		Occurrence	7	1.10	9833.60	75718.72	
Interim Medical Monitoring and Treatment (IMMT) Total:							386144.68
IMMT, HHA		15 Minutes	1	935.70	10.86	10161.70	
IMMT, RN		15 Minutes	5	935.70	10.86	50808.51	
FFS IMMT, HHA		15 Minutes	6	935.70	10.86	60970.21	
FFS IMMT, RN		15 Minutes	26	935.70	10.86	264204.25	
Medical Day Care for Children Total:							1776096.00
Medical Day Care for Children		15 Minutes	24	5600.00	8.81	1184064.00	
FFS Medical Day Care for Children		15 Minutes	12	5600.00	8.81	592032.00	
Personal Emergency Response System or Portable Locator System Total:							155096.64
Personal Emergency Response - Initial		Installation	23	1.00	1067.73	24557.79	
Personal Emergency Response - Ongoing		Month	356	9.27	38.37	126625.60	
FFS Personal Emergency Response - Initial		Installation	1	1.00	1067.73	1067.73	
FFS Personal Emergency		Month				2845.52	
<p style="text-align: right;">GRAND TOTAL: 64866864.21</p> <p style="text-align: right;">Total: Services included in capitation: 58939873.71</p> <p style="text-align: right;">Total: Services not included in capitation: 5926990.50</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 37130.43</p> <p style="text-align: right;">Services included in capitation: 33737.76</p> <p style="text-align: right;">Services not included in capitation: 3392.67</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response - Ongoing			8	9.27	38.37		
Positive Behavioral Support and Consultation Total:							1594.80
Behavioral Programming		15 Minutes	9	12.00	13.29	1435.32	
FFS Behavioral Programming		15 Minutes	1	12.00	13.29	159.48	
Skilled Attendant Care Total:							105490.95
Attendant Care Agency		15 Minutes	17	831.03	5.77	81515.73	
FFS Attendant Care Agency		15 Minutes	5	831.03	5.77	23975.22	
Supported Community Living Total:							51660470.13
Supported Community Living - 15 Minutes		15 Minutes	287	982.78	34.15	9632275.92	
Supported Community Living - Daily		Day	134	254.73	1176.56	40160487.26	
FFS Supported Community Living - 15 Minutes		15 Minutes	11	982.78	34.15	369181.31	
FFS Supported Community Living - Daily		Day	5	254.73	1176.56	1498525.64	
Transportation Total:							2339843.39
Transportation - Mile		Mile	162	381.17	8.66	534751.02	
Transportation - Trip		Trip	140	205.31	38.35	1102309.39	
FFS Transportation - Mile		Mile	3	381.17	8.66	9902.80	
FFS Transportation - Trip		Trip	88	205.31	38.35	692880.19	
<p style="text-align: right;">GRAND TOTAL: 64866864.21</p> <p style="text-align: right;">Total: Services included in capitation: 58939873.71</p> <p style="text-align: right;">Total: Services not included in capitation: 5926990.50</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 37130.43</p> <p style="text-align: right;">Services included in capitation: 33737.76</p> <p style="text-align: right;">Services not included in capitation: 3392.67</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							425641.82
Adult Day Care - Extended Day		Extended Day	4	45.57	120.85	22028.54	
Adult Day Care - 15 Minutes		15 Minutes	1	313.86	7.56	2372.78	
Adult Day Care - Half Day		Half Day	33	13.33	68.85	30286.43	
Adult Day Care - Full Day		Full Day	106	31.73	106.67	358771.74	
FFS Adult Day Care - Extended Day		Extended Day	1	45.57	120.85	5507.13	
FFS Adult Day Care - 15 minutes		15 Minutes	1	313.86	7.56	2372.78	
FFS Adult Day Care - Half Day		Half Day	1	13.33	68.85	917.77	
FFS Adult Day Care - Full Day		Full Day	1	31.73	106.67	3384.64	
Case Management Total:							1381418.93
Case Management 15 minutes		15 Minutes	10	122.06	71.63	87431.58	
FFS Case Management 15 minutes		15 Minutes	148	122.06	71.63	1293987.35	
Prevocational Services Total:							60673.20
Prevocational Services, Hour		Hour	8	361.15	11.20	32359.04	
<p>GRAND TOTAL: 66727973.86</p> <p>Total: Services included in capitation: 60670378.45</p> <p>Total: Services not included in capitation: 6057595.41</p> <p>Total Estimated Unduplicated Participants: 1747</p> <p>Factor D (Divide total by number of participants): 38195.75</p> <p>Services included in capitation: 34728.32</p> <p>Services not included in capitation: 3467.43</p> <p>Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services, Career Exploration, Hour		Hour	4	361.15	11.20	16179.52	
FFS Prevocational services, Hour		Hour	2	361.15	11.20	8089.76	
FFS Prevocational Services, Career Exploration, Hour		Hour	1	361.15	11.20	4044.88	
Respite Total:							4429132.15
Respite - HHA Specialized		15 Minutes	10	3178.95	3.59	114124.30	
Respite - Child Care		15 Minutes	2	794.14	2.83	4494.83	
Respite - Home Care Agency & Non-Facility, Group		15 Minutes	68	1908.95	2.61	338800.45	
Respite - Resident Camp - Weeklong		15 Minutes	2	455.27	2.05	1866.61	
Respite - Teen Day Camp - 13 to 21 years old		15 Minutes	1	1072.85	4.16	4463.06	
Respite - Group Specialized Summer Day Camp		15 Minutes	7	646.08	2.61	11803.88	
Respite - HHA Basic Individual		15 Minutes	73	2078.39	3.06	464270.76	
Respite - Home Care Agency & Non-Facility, Basic Individual		15 Minutes	296	2608.08	3.44	2655651.38	
Respite - Camp		15 Minutes	1	15.84	2.62	41.50	
Respite - Weekend On-Site Respite - Camp		15 Minutes	2	2787.02	2.73	15217.13	
Respite - hospital or nursing		15 Minutes	1	2185.28	2.82	6162.49	
<p style="text-align: right;">GRAND TOTAL: 66727973.86</p> <p style="text-align: right;">Total: Services included in capitation: 60670378.45</p> <p style="text-align: right;">Total: Services not included in capitation: 6057595.41</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 38195.75</p> <p style="text-align: right;">Services included in capitation: 34728.32</p> <p style="text-align: right;">Services not included in capitation: 3467.43</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
facility/skilled							
Respite - Home Care Agcy & Non-Facility, Specialized		15 Minutes	9	316.71	36.13	102984.59	
Respite - Foster Group Care		15 Minutes	1	7.92	2.85	22.57	
Respite - RCF		15 Minutes	1	3800.49	2.67	10147.31	
Respite - Adult Day Care		15 Minutes	1	197.94	5.32	1053.04	
Respite - ICF/ID		15 Minutes	1	3800.49	2.67	10147.31	
FFS Respite - HHA Specialized		15 Minutes	2	3178.95	3.59	22824.86	
FFS Respite - Child Care		15 Minutes	1	794.14	2.83	2247.42	
FFS Respite - Home Care Agcy & Non-Facility, Group		15 Minutes	11	1908.95	2.61	54805.95	
FFS Respite - Resident Camp - Weeklong		15 Minutes	1	455.27	2.05	933.30	
FFS Respite - Teen Day Camp - 13 to 21 years old		15 Minutes	1	1072.85	4.16	4463.06	
FFS Respite - Group Specialized Summer Day Camp		15 Minutes	1	646.08	2.61	1686.27	
FFS Respite - HHA Basic Individual		15 Minutes	12	2078.39	3.06	76318.48	
FFS Respite - Home Care Agcy & Non-Facility, Basic Individual		15 Minutes	52	2608.08	3.44	466533.35	
FFS Respite - Camp		15 Minutes	1	15.84	2.62	41.50	
FFS Respite - Weekend On-Site Respite - Camp		15 Minutes	1	2787.02	2.73	7608.56	
FFS Respite -						6162.49	
<p style="text-align: right;">GRAND TOTAL: 66727973.86</p> <p style="text-align: right;">Total: Services included in capitation: 60670378.45</p> <p style="text-align: right;">Total: Services not included in capitation: 6057595.41</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 38195.75</p> <p style="text-align: right;">Services included in capitation: 34728.32</p> <p style="text-align: right;">Services not included in capitation: 3467.43</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
hospital or nursing facility/skilled		15 Minutes	1	2185.28	2.82		
FFS Respite - Home Care Agency & Non-Facility, Specialized		15 Minutes	2	316.71	36.13	22885.46	
FFS Respite - Foster Group Care		15 Minutes	1	7.92	2.85	22.57	
FFS Respite - RCF		15 Minutes	1	3800.49	2.67	10147.31	
FFS Respite - Adult Day Care		15 Minutes	1	197.94	5.32	1053.04	
FFS Respite - ICF/ID		15 Minutes	1	3800.49	2.67	10147.31	
Supported Employment Total:							85836.02
Individual Supported Employment Hour		Hour	33	3.53	342.20	39862.88	
Small Group Supported Employment 15 Minutes		15 Minutes	14	599.26	1.18	9899.78	
Long Term Job Coaching - Monthly		Month	61	9.27	41.35	23382.18	
Long Term Job Coaching - Hour		Hour	8	17.63	40.61	5727.63	
FFS Individual Supported Employment Hour		Hour	3	3.53	342.20	3623.90	
FFS Small Group Supported Employment 15 Minutes		15 Minutes	1	599.26	1.18	707.13	
FFS Long Term Job Coaching - Monthly		Month	5	9.27	41.35	1916.57	
FFS Long Term Job Coaching - Hour		Hour	1	17.63	40.61	715.95	
Specialized Medical							25093.29
<p style="text-align: right;">GRAND TOTAL: 66727973.86</p> <p style="text-align: right;">Total: Services included in capitation: 60670378.45</p> <p style="text-align: right;">Total: Services not included in capitation: 6057595.41</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 38195.75</p> <p style="text-align: right;">Services included in capitation: 34728.32</p> <p style="text-align: right;">Services not included in capitation: 3467.43</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment Total:							
Specialized Medical Equipment		Occurrence	7	49.00	15.01	5148.43	
FFS Specialized Medical Equipment		Occurrence	6	1.08	3077.91	19944.86	
Financial Management Service Total:							431437.86
Financial Management Service		Month	442	10.31	74.44	339224.57	
FFS Financial Management Service		Month	111	11.16	74.44	92213.29	
Independent Support Broker Total:							48806.92
Independent Support Broker		Month	376	9.27	6.19	21575.37	
FFS Independent Support Broker		Month	102	9.27	28.80	27231.55	
Individual Directed Goods and Services Total:							119080.94
Individual Directed Goods and Services		Month	416	9.27	28.79	111023.45	
FFS Individual Directed Goods and Services		Month	53	9.27	16.40	8057.48	
Attendant Care Total:							1022665.52
Attendant Care Agency		15 Minutes	162	831.03	5.86	788913.40	
FFS Attendant Care Agency		15 Minutes	48	831.03	5.86	233752.12	
Enabling Technology for Remote Support Total:							174591.46
1 Job (equipment/technology)		1 Job	25	238.80	14.06	83938.20	
1 Assessment						83938.20	
<p style="text-align: right;">GRAND TOTAL: 66727973.86</p> <p style="text-align: right;">Total: Services included in capitation: 60670378.45</p> <p style="text-align: right;">Total: Services not included in capitation: 6057595.41</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 38195.75</p> <p style="text-align: right;">Services included in capitation: 34728.32</p> <p style="text-align: right;">Services not included in capitation: 3467.43</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1 Assessment	25	238.80	14.06		
FFS 1 Job (equipment/ technology)		1 Job	1	238.80	14.06	3357.53	
FFS 1 Assessment		1 Assessment	1	238.80	14.06	3357.53	
Family Training Services Total:							87295.73
Family Counseling and Training Services		15 Minutes	25	238.80	14.06	83938.20	
FFS Family Counseling and Training Services		15 Minutes	1	238.80	14.06	3357.53	
Home and Vehicle Modification Total:							388885.05
Home and Vehicle Modification		Occurrence	54	1.10	5253.04	312030.58	
FFS Home and Vehicle Modification		Occurrence	7	1.10	9981.10	76854.47	
Interim Medical Monitoring and Treatment (IMMT) Total:							391833.73
IMMT, HHA		15 Minutes	1	935.70	11.02	10311.41	
IMMT, RN		15 Minutes	5	935.70	11.02	51557.07	
FFS IMMT, HHA		15 Minutes	6	935.70	11.02	61868.48	
FFS IMMT, RN		15 Minutes	26	935.70	11.02	268096.76	
Medical Day Care for Children Total:							1802304.00
Medical Day Care for Children		15 Minutes	24	5600.00	8.94	1201536.00	
FFS Medical Day Care for Children		15 Minutes	12	5600.00	8.94	600768.00	
Personal Emergency Response System or Portable Locator System							159243.54
<p style="text-align: right;">GRAND TOTAL: 66727973.86</p> <p style="text-align: right;">Total: Services included in capitation: 60670378.45</p> <p style="text-align: right;">Total: Services not included in capitation: 6057595.41</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 38195.75</p> <p style="text-align: right;">Services included in capitation: 34728.32</p> <p style="text-align: right;">Services not included in capitation: 3467.43</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Personal Emergency Response - Initial		Installation	23	1.00	1083.75	24926.25	
Personal Emergency Response - Ongoing		Month	361	9.27	38.95	130345.01	
FFS Personal Emergency Response - Initial		Installation	1	1.00	1083.75	1083.75	
FFS Personal Emergency Response - Ongoing		Month	8	9.27	38.95	2888.53	
Positive Behavioral Support and Consultation Total:							1618.80
Behavioral Programming		15 Minutes	9	12.00	13.49	1456.92	
FFS Behavioral Programming		15 Minutes	1	12.00	13.49	161.88	
Skilled Attendant Care Total:							107136.39
Attendant Care Agency		15 Minutes	17	831.03	5.86	82787.21	
FFS Attendant Care Agency		15 Minutes	5	831.03	5.86	24349.18	
Supported Community Living Total:							53179429.72
Supported Community Living - 15 Minutes		15 Minutes	291	982.78	34.66	9912378.05	
Supported Community Living - Daily		Day	136	254.73	1194.21	41371351.41	
FFS Supported Community Living - 15 Minutes		15 Minutes	11	982.78	34.66	374694.70	
FFS Supported Community Living - Daily		Day	5	254.73	1194.21	1521005.57	
Transportation Total:							2405848.81
<p style="text-align: right;">GRAND TOTAL: 66727973.86</p> <p style="text-align: right;">Total: Services included in capitation: 60670378.45</p> <p style="text-align: right;">Total: Services not included in capitation: 6057595.41</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 38195.75</p> <p style="text-align: right;">Services included in capitation: 34728.32</p> <p style="text-align: right;">Services not included in capitation: 3467.43</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation - Mile		Mile	164	381.17	8.79	549479.43	
Transportation - Trip		Trip	142	205.31	38.93	1134966.00	
FFS Transportation - Mile		Mile	3	381.17	8.79	10051.45	
FFS Transportation - Trip		Trip	89	205.31	38.93	711351.93	
<p style="text-align: right;">GRAND TOTAL: 6672793.86</p> <p style="text-align: right;">Total: Services included in capitation: 60670378.45</p> <p style="text-align: right;">Total: Services not included in capitation: 6057595.41</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 38195.75</p> <p style="text-align: right;">Services included in capitation: 34728.32</p> <p style="text-align: right;">Services not included in capitation: 3467.43</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							438893.08
Adult Day Care - Extended Day		Extended Day	4	45.57	122.66	22358.46	
Adult Day Care - 15 Minutes		15 Minutes	1	313.86	7.67	2407.31	
Adult Day Care - Half Day		Half Day	33	13.33	69.88	30739.51	
Adult Day Care - Full Day		Full Day	108	31.73	108.27	371023.97	
<p style="text-align: right;">GRAND TOTAL: 68628726.39</p> <p style="text-align: right;">Total: Services included in capitation: 62438307.35</p> <p style="text-align: right;">Total: Services not included in capitation: 6190419.04</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 39283.76</p> <p style="text-align: right;">Services included in capitation: 35740.30</p> <p style="text-align: right;">Services not included in capitation: 3543.46</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS Adult Day Care - Extended Day		Extended Day	1	45.57	122.66	5589.62	
FFS Adult Day Care - 15 minutes		15 Minutes	1	313.86	7.67	2407.31	
FFS Adult Day Care - Half Day		Half Day	1	13.33	69.88	931.50	
FFS Adult Day Care - Full Day		Full Day	1	31.73	108.27	3435.41	
Case Management Total:							1419801.92
Case Management 15 minutes		15 Minutes	10	122.06	72.70	88737.62	
FFS Case Management 15 minutes		15 Minutes	150	122.06	72.70	1331064.30	
Prevocational Services Total:							61594.13
Prevocational Services, Hour		Hour	8	361.15	11.37	32850.20	
Prevocational Services, Career Exploration, Hour		Hour	4	361.15	11.37	16425.10	
FFS Prevocational services, Hour		Hour	2	361.15	11.37	8212.55	
FFS Prevocational Services, Career Exploration, Hour		Hour	1	361.15	11.37	4106.28	
Respite Total:							4551822.98
Respite - HHA Specialized		15 Minutes	10	3178.95	3.64	115713.78	
Respite - Child Care		15 Minutes	2	794.14	2.87	4558.36	
Respite - Home Care Agcy & Non-Facility, Group		15 Minutes	69	1908.95	2.65	349051.51	
Respite - Resident Camp - Weeklong		15 Minutes	2	455.27	2.08	1893.92	
<p style="text-align: right;">GRAND TOTAL: 68628726.39</p> <p style="text-align: right;">Total: Services included in capitation: 62438307.35</p> <p style="text-align: right;">Total: Services not included in capitation: 6190419.04</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 39283.76</p> <p style="text-align: right;">Services included in capitation: 35740.30</p> <p style="text-align: right;">Services not included in capitation: 3543.46</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite - Teen Day Camp - 13 to 21 years old		15 Minutes	1	1072.85	4.22	4527.43	
Respite - Group Specialized Summer Day Camp		15 Minutes	7	646.08	2.65	11984.78	
Respite - HHA Basic Individual		15 Minutes	74	2078.39	3.11	478320.67	
Respite - Home Care Agcy & Non-Facility, Basic Individual		15 Minutes	300	2608.08	3.49	2730659.76	
Respite - Camp		15 Minutes	1	15.84	2.66	42.13	
Respite - Weekend On-Site Respite - Camp		15 Minutes	2	2787.02	2.77	15440.09	
Respite - hospital or nursing facility/skilled		15 Minutes	1	2185.28	2.86	6249.90	
Respite - Home Care Agcy & Non-Facility, Specialized		15 Minutes	9	316.71	36.67	104523.80	
Respite - Foster Group Care		15 Minutes	1	7.92	2.89	22.89	
Respite - RCF		15 Minutes	1	3800.49	2.71	10299.33	
Respite - Adult Day Care		15 Minutes	1	197.94	5.40	1068.88	
Respite - ICF/ID		15 Minutes	1	3800.49	2.71	10299.33	
FFS Respite - HHA Specialized		15 Minutes	2	3178.95	3.64	23142.76	
FFS Respite - Child Care		15 Minutes	1	794.14	2.87	2279.18	
FFS Respite - Home Care Agcy & Non-Facility, Group		15 Minutes	11	1908.95	2.65	55645.89	
FFS Respite - Resident Camp -		15 Minutes	1	455.27	2.08	946.96	

GRAND TOTAL: 68628726.39

Total: Services included in capitation: 62438307.35

Total: Services not included in capitation: 6190419.04

Total Estimated Unduplicated Participants: 1747

Factor D (Divide total by number of participants): 39283.76

Services included in capitation: 35740.30

Services not included in capitation: 3543.46

Average Length of Stay on the Waiver: 279

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Weeklong							
FFS Respite - Teen Day Camp - 13 to 21 years old		15 Minutes	1	1072.85	4.22	4527.43	
FFS Respite - Group Specialized Summer Day Camp		15 Minutes	1	646.08	2.65	1712.11	
FFS Respite - HHA Basic Individual		15 Minutes	12	2078.39	3.11	77565.51	
FFS Respite - Home Care Agcy & Non-Facility, Basic Individual		15 Minutes	53	2608.08	3.49	482416.56	
FFS Respite - Camp		15 Minutes	1	15.84	2.66	42.13	
FFS Respite - Weekend On-Site Respite - Camp		15 Minutes	1	2787.02	2.77	7720.05	
FFS Respite - hospital or nursing facility/skilled		15 Minutes	1	2185.28	2.86	6249.90	
FFS Respite - Home Care Agcy & Non-Facility, Specialized		15 Minutes	2	316.71	36.67	23227.51	
FFS Respite - Foster Group Care		15 Minutes	1	7.92	2.89	22.89	
FFS Respite - RCF		15 Minutes	1	3800.49	2.71	10299.33	
FFS Respite - Adult Day Care		15 Minutes	1	197.94	5.40	1068.88	
FFS Respite - ICF/ID		15 Minutes	1	3800.49	2.71	10299.33	
Supported Employment Total:							87532.90
Individual Supported Employment Hour		Hour	33	3.53	347.33	40460.47	
Small Group Supported Employment 15 Minutes		15 Minutes	14	599.26	1.20	10067.57	
<p style="text-align: right;">GRAND TOTAL: 68628726.39</p> <p style="text-align: right;">Total: Services included in capitation: 62438307.35</p> <p style="text-align: right;">Total: Services not included in capitation: 6190419.04</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 39283.76</p> <p style="text-align: right;">Services included in capitation: 35740.30</p> <p style="text-align: right;">Services not included in capitation: 3543.46</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Long Term Job Coaching - Monthly		Month	62	9.27	41.97	24121.84	
Long Term Job Coaching - Hour		Hour	8	17.63	41.22	5813.67	
FFS Individual Supported Employment Hour		Hour	3	3.53	347.33	3678.22	
FFS Small Group Supported Employment 15 Minutes		15 Minutes	1	599.26	1.20	719.11	
FFS Long Term Job Coaching - Monthly		Month	5	9.27	41.97	1945.31	
FFS Long Term Job Coaching - Hour		Hour	1	17.63	41.22	726.71	
Specialized Medical Equipment Total:							25471.36
Specialized Medical Equipment		Occurrence	7	49.00	15.24	5227.32	
FFS Specialized Medical Equipment		Occurrence	6	1.08	3124.08	20244.04	
Financial Management Service Total:							445068.80
Financial Management Service		Month	449	10.31	75.56	349781.60	
FFS Financial Management Service		Month	113	11.16	75.56	95287.20	
Independent Support Broker Total:							50418.42
Indepedent Support Broker		Month	382	9.27	6.28	22238.36	
FFS Independent Support Broker		Month	104	9.27	29.23	28180.06	
Individual Directed Goods and Services							122641.54
<p style="text-align: right;">GRAND TOTAL: 68628726.39</p> <p style="text-align: right;">Total: Services included in capitation: 62438307.35</p> <p style="text-align: right;">Total: Services not included in capitation: 6190419.04</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 39283.76</p> <p style="text-align: right;">Services included in capitation: 35740.30</p> <p style="text-align: right;">Services not included in capitation: 3543.46</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Individual Directed Goods and Services		Month	422	9.27	29.22	114306.89	
FFS Individual Directed Goods and Services		Month	54	9.27	16.65	8334.66	
Attendant Care Total:							1053205.87
Attendant Care Agency		15 Minutes	164	831.03	5.95	810919.07	
FFS Attendant Care Agency		15 Minutes	49	831.03	5.95	242286.80	
Enabling Technology for Remote Support Total:							177199.15
1 Job (equipment/ technology)		1 Job	25	238.80	14.27	85191.90	
1 Assessment		1 Assessment	25	238.80	14.27	85191.90	
FFS 1 Job (equipment/ technology)		1 Job	1	238.80	14.27	3407.68	
FFS 1 Assessment		1 Assessment	1	238.80	14.27	3407.68	
Family Training Services Total:							88599.58
Family Counseling and Training Services		15 Minutes	25	238.80	14.27	85191.90	
FFS Family Counseling and Training Services		15 Minutes	1	238.80	14.27	3407.68	
Home and Vehicle Modification Total:							400583.63
Home and Vehicle Modification		Occurrence	55	1.10	5331.84	322576.32	
FFS Home and Vehicle Modification		Occurrence	7	1.10	10130.82	78007.31	
Interim Medical Monitoring and Treatment							397878.35
<p style="text-align: right;">GRAND TOTAL: 68628726.39</p> <p style="text-align: right;">Total: Services included in capitation: 62438307.35</p> <p style="text-align: right;">Total: Services not included in capitation: 6190419.04</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 39283.76</p> <p style="text-align: right;">Services included in capitation: 35740.30</p> <p style="text-align: right;">Services not included in capitation: 3543.46</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(IMMT) Total:							
IMMT, HHA		15 Minutes	1	935.70	11.19	10470.48	
IMMT, RN		15 Minutes	5	935.70	11.19	52352.42	
FFS IMMT, HHA		15 Minutes	6	935.70	11.19	62822.90	
FFS IMMT, RN		15 Minutes	26	935.70	11.19	272232.56	
Medical Day Care for Children Total:							1828512.00
Medical Day Care for Children		15 Minutes	24	5600.00	9.07	1219008.00	
FFS Medical Day Care for Children		15 Minutes	12	5600.00	9.07	609504.00	
Personal Emergency Response System or Portable Locator System Total:							163449.96
Personal Emergency Response - Initial		Installation	23	1.00	1100.01	25300.23	
Personal Emergency Response - Ongoing		Month	366	9.27	39.53	134118.17	
FFS Personal Emergency Response - Initial		Installation	1	1.00	1100.01	1100.01	
FFS Personal Emergency Response - Ongoing		Month	8	9.27	39.53	2931.54	
Positive Behavioral Support and Consultation Total:							1642.80
Behavioral Programming		15 Minutes	9	12.00	13.69	1478.52	
FFS Behavioral Programming		15 Minutes	1	12.00	13.69	164.28	
Skilled Attendant Care Total:							108781.83
<p align="center">GRAND TOTAL: 68628726.39</p> <p align="center">Total: Services included in capitation: 62438307.35</p> <p align="center">Total: Services not included in capitation: 6190419.04</p> <p align="center">Total Estimated Unduplicated Participants: 1747</p> <p align="center">Factor D (Divide total by number of participants): 39283.76</p> <p align="center">Services included in capitation: 35740.30</p> <p align="center">Services not included in capitation: 3543.46</p> <p align="center">Average Length of Stay on the Waiver: 279</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Agency		15 Minutes	17	831.03	5.95	84058.68	
FFS Attendant Care Agency		15 Minutes	5	831.03	5.95	24723.14	
Supported Community Living Total:							54732861.17
Supported Community Living - 15 Minutes		15 Minutes	295	982.78	35.18	10199389.12	
Supported Community Living - Daily		Day	138	254.73	1212.12	42609339.21	
FFS Supported Community Living - 15 Minutes		15 Minutes	11	982.78	35.18	380316.20	
FFS Supported Community Living - Daily		Day	5	254.73	1212.12	1543816.64	
Transportation Total:							2472766.91
Transportation - Mile		Mile	166	381.17	8.92	564406.04	
Transportation - Trip		Trip	144	205.31	39.51	1168098.93	
FFS Transportation - Mile		Mile	3	381.17	8.92	10200.11	
FFS Transportation - Trip		Trip	90	205.31	39.51	730061.83	
<p style="text-align: right;">GRAND TOTAL: 68628726.39</p> <p style="text-align: right;">Total: Services included in capitation: 62438307.35</p> <p style="text-align: right;">Total: Services not included in capitation: 6190419.04</p> <p style="text-align: right;">Total Estimated Unduplicated Participants: 1747</p> <p style="text-align: right;">Factor D (Divide total by number of participants): 39283.76</p> <p style="text-align: right;">Services included in capitation: 35740.30</p> <p style="text-align: right;">Services not included in capitation: 3543.46</p> <p style="text-align: right;">Average Length of Stay on the Waiver: 279</p>							