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	Prevocational Services		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Independent Support Broker		
Supports for Participant Direction	Individual Directed Goods and Services		
Other Service	Assistive Devices		
Other Service	Community Transition Services		
Other Service	Family and Community Support		
Other Service	Home and Vehicle Modifications		
Other Service	Home-Delivered Meals		
Other Service	Medical Day Care for Children		
Other Service	Peer Mentoring		
Other Service	Personal Emergency Response System or Portable Locator System		
Other Service	Positive Behavioral Support and Consultation		
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:

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:**

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

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

Service Definition *(Scope):*

Prevocational Services 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 individual or small group Supported Employment services.

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

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

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

A unit of service is one hour.

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, and Prevocational Services; 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 or 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 servicesand 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 option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding

Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Prevocational Service Provider

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers accredited by the Council on Quality and Leadership (CQL), International Center for Clubhouse Development, or Commission on Accreditation of Rehabilitation Facilities (CARF) as an organizational employment service provider or a community employment service provider in accordance with Iowa Administrative Code 441.77.

Other Standard *(specify):*

Providers responsible for the payroll of persons receiving supports shall have policies that ensure compliance with state and federal labor laws and regulations, as prescribed in the HCBS Provider Manual:
(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.

The Prevocational Services Provider Agency is responsible to ensure that direct support staff providing Prevocational service shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule and manual:
(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age. 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:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Respite care services are services provided to the 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. 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.

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

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

A unit of service is a 15-minute unit.

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) for basic individual respite, 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. 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 option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Foster Care Facility
Agency	Home Health Agency
Agency	HCBS Certified Respite Provider
Agency	Adult Day Care Provider
Agency	Camps
Agency	Nursing Facilities, ICF/ID, and Hospitals
Agency	Child Care Facility
Agency	Assisted Living Programs
Agency	Residential Care Facility
Agency	Home Care Provider

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 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:

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:

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:

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 Chapter 70

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:

Camps

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Respite care providers certified in accordance with Iowa Administrative Code 441- Chapter 77.
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) 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:

Nursing Facilities, ICF/ID, and Hospitals

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 Chapter 58 (NF) 64 (ICF/ID) 51 (Hospitals)

• 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.

Certificate *(specify):*

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.

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.
(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 Programs

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. Chapter 69

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:

Residential Care Facility

Provider Qualifications

License *(specify):*

Residential care facilities licensed and in good standing by the Department of Inspections and Appeals and Licensing under Iowa Administrative Code 481 Chapter 57

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 Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Eligible home care agencies are those that meet the conditions set forth in Iowa Administrative Code 441 Chapter 77.
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):*

Home care agencies that meet the requirements set forth in department of public health rule IAC 64180.7(135): Professional staff as providers of home care aide services. An individual who is in the process of receiving or who has completed the training required for LPN or RN licensure or who possesses an associate degree or higher in social work, sociology, home economics or other health or human services field may be assigned to provide home care aide services if the following conditions are met:
a. Services or tasks assigned are appropriate to the individual's prior training.
b. Orientation to home care is conducted. Orientation includes adaptation of the individual's knowledge and skills from prior education to the home setting and to the role of the home care aide.

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: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

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

Service Definition *(Scope):*

Supported Employment 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 Supported Employment (including Supported Self-Employment)
• Long-Term Job Coaching
• Small Group Supported Employment

Expected outcome of Supported Employment services.
• The expected outcome of Supported Employment 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.

Supported Employment Setting. Supported Employment services shall take place in integrated work settings. For self-employment, the person's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where persons are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public. Individualized employment strategies include but are not limited to: customized employment, person placement and support, and supported self-employment.

Supported Employment Service activities. Activities are personized and may include any combination of the following:
1) Benefits education
2) Career exploration (e.g., tours, informational interviews, job shadows).
3) Employment assessment.
4) Assistive technology assessment.
5) Trial work experience.
6) Person-centered employment planning.
7) Development of visual/traditional résumés.
8) Job-seeking skills training and support.
9) Outreach to prospective employers on behalf of the person (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the person; employer needs analysis).
10) Job analysis (e.g., work site assessment or job accommodations evaluation).
11) Identifying and arranging transportation.
12) Career advancement services (e.g., assisting a person in making an upward career move or seeking promotion from an existing employer).
13) Re-employment services (if necessary due to job loss).
14) Financial literacy and asset development.
15) Other employment support services deemed necessary to enable the person to obtain employment.
16) Systematic instruction and support during initial on-the-job training including initial on the job training to stabilization.
17) Engagement of natural supports during initial period of employment.
18) Implementation of assistive technology solutions during initial period of employment.
19) Transportation of the person during service hours.

Self-employment. Individualized employment may also include support to establish a viable self-employment opportunity, including home- based self-employment.

Expected outcome of Supported Self-Employment services.
• An expected outcome of Supported Self-Employment is that the person earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

Supported Self-Employment Service activities. To establish self-employment, activities may include:
1) Aid to the person in identifying potential business opportunities.
2) Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3) Identification of the long-term supports necessary for the 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.

In addition, activities to maintain self-employment may include:
1) Ongoing identification of the supports necessary for the person to operate the business;
2) Ongoing assistance, counseling and guidance to maintain and grow the business; and
3) Ongoing benefits education and support.

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

Expected outcome of Long-Term Job Coaching services.
• Successful transition to Long-Term Job Coaching, if needed, is an expected outcome.

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

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

Small-Group Supported Employment. Small group Supported Employment services are training, and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. Small-group Supported Employment services must be provided in a manner that promotes 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.

Expected outcome of Small-Group Supported Employment service. Small group Supported Employment services are expected to enable the person to make reasonable and continued progress toward person employment. Participation in small group Supported Employment services is not a prerequisite for Supported Employment 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 an 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 Supported Employment Setting. Small-group Supported Employment services shall take place in integrated,

community-based nonresidential settings separate from the person's residence.

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

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:

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, and Prevocational Services); 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 servicesand 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 option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	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):*

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

Other Standard *(specify):*

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 the HHS Learning Management System or other 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 the HHS Learning Management System or other 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:

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):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

The Financial Management Service (FMS) is necessary for all 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 IoWANS.

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 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**

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 Services Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Financial Management Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Financial Institution or a Financial Management Service Agency registered as a business entity with the Secretary of State and enrolled with Iowa Medicaid meeting all of the requirements outlined in this section, including:

a. The financial institution shall:

(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or

(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC); or

b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.

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

d. The financial institution shall enroll as a Medicaid provider.

(3) The F/EA is required by contract to operate in accordance with Section 3504 of the Internal Revenue Code, per Revenue Procedure 70-6 and Section 3504 Agent Employment Tax Liability proposed regulations (REG-137036-08) issued by the IRS on January 13, 2010. The F/EA must meet all applicable Participant Direction-related Federal and State requirements. The CHC-MCO must meet all additional requirements as stated in the CHC Agreement; and

(4) An FMS provider must be able to demonstrate initial and continuing financial solvency with evidence that 30 days coverage of operational costs are met (Note: Cash requirements will be estimated using the past quarter's performance from the date of review, or, if a new entity, the provider must estimate the number of participant that they reasonably expect to serve using nominal costs.)

a. Each entity or company applying as an FMS provider must supply financial documentation for review. This documentation must include:
ii. The three most current bank statements;
iii. An open letter of credit statement[s] from bank/lending institution), if applicable;
iv. A current balance sheet; and
v. A schedule of anticipated monthly expenditures.

b. Each entity or company providing FMS must supply financial documentation for review as detailed in Section VIII Quality Assurance and Program Integrity. This documentation must include:
i. Independent GAAP audit by a certified public accountant
ii. Program and Financial Compliance Audit

(5) The FMS provider will complete background checks of management personnel and owners in compliance with federal provider enrollment screening requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: 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):

Independent Support Broker

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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 Rules.
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.
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.
7) Assist the person with negotiating with entities providing services and supports.
8) Assist the person with contracts and payment methods for services and supports.
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.

This service does not duplicate other waiver services, including case management.

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

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

The 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 servicesand 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.

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

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent 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:

Independent Support Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

People who elect the consumer choices option may choose to 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:

Financial Management System Provider and 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:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**

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

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

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

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

Service Definition *(Scope):*

Individual-Directed Goods and Services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the 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 (if opting to work with an 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.

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

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

Individual Directed Goods and Services must be documented on the individual budget. The individual budget limit will be based on the 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 for which the person is eligible.
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 person'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 servicesand 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 option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	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:

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.

Certificate *(specify):*

Other Standard *(specify):*

In accordance with Iowa Administrative Code 441 Chapter 77

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver enrollee, Independent Support Broker, Financial Management Service and 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:

Assistive Devices

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Assistive Devices are practical equipment products that assist persons with activities of daily living and instrumental activities of daily living and allow the person more independence. Assistive Devices are not medical in nature.

Assistive Devices include, but are not limited to:
1) Long reach brushes,
2) Extra-long shoehorns,
3) Non-slip grippers to pick up and reach items,
4) Dressing aids,
5) Shampoo rinse trays and inflatable shampoo trays,
6) Double handed cups, and
7) Sipper lids.

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 item. The limit per unit is published in the Iowa Administrative Code.

For each unit of service provided, the case manager shall ensure that the service has a direct relationship to the person's need.

The person's case manager is responsible for oversight to avoid duplication of services 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 option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Area Agency on Aging or Subcontractor with AAA
Agency	Community Business
Agency	Medical Equipment and Supply Dealers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Devices

Provider Category:

Agency

Provider Type:

Area Agency on Aging or Subcontractor with AAA

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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 for monitoring 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: Assistive Devices

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 assistive devices and that Submit verification of current liability and workers' compensation coverage. For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are

provided in a safe and effective manner.

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

An OHCDS arrangement must be in place when utilizing subcontractors.

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: Assistive Devices

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

Other Standard *(specify):*

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:

Community Transition Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Community Transitions Services are non-recurring set-up expenses for
1) persons who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses, and
2) youth in transition to adult programs and services.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:
1) Security deposits that are required to obtain a lease on an apartment or home;
2) Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
3) Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
4) Fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state issued ID, or criminal background check;
5) Services necessary for the person’s health and safety such as pest eradication and one-time cleaning prior to occupancy;
6) Moving expenses; and,
7) Activities to assess need, arrange for and procure needed resources.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the person-centered service plan, clearly identified in the person-centered service plan and the person is unable to meet such expense, or when the services cannot be obtained from other sources.

Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

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:

The unit is one item. One-time set-up expenses are limited to $1500 per person per transition.

Community Transition Services may be authorized for a 365-day period for youth in transition into adult programs and services.
Excluded services and costs. Services, activities, costs, and time that are not covered and for which payment shall not be made for include:
(1) Furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.
(2) Room and board
(3) Monthly rental or mortgage expenses
(4) Escrow
(5) Insurance
(6) Food
(7) Regular utility charges
(8) Household appliances or items that are intended for purely diversional/recreational purposes.

The person’s case manager is responsible for oversight to avoid duplication of servicesand 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 option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	**Community Business**
Agency	**Community Action Agency**
Agency	**Agency Certified to Provide Supported Community Living**
Agency	**Area Agency on Aging or Subcontractor with AAA**
Agency	**Center for Independent Living (CIL)**

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

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 Community Transition Services must submit verification of current liability and workers' compensation coverage.

For this service, the department does not have specific standards for subcontracts or providers regarding training, 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 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 Community Transition 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 agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

Individuals delivering services are required to complete training commensurate with the diagnoses and needs of the persons served.

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).

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: Community Transition Services

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

Individuals delivering services are required to 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: Community Transition Services

Provider Category:

Agency

Provider Type:

Agency Certified to Provide Supported Community Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers certified by the HCBS Quality Improvement Organization 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, 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 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 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.

Individuals delivering services are required to 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: Community Transition Services

Provider Category:

Agency

Provider Type:

Area Agency on Aging or Subcontractor with AAA

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Providers subcontracting with the Area Agencies on Aging.

For this service, the department does not have specific standards for subcontracts or providers regarding training, 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 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 or trained 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.

Individuals delivering services are required to 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: Community Transition Services

Provider Category:

Agency

Provider Type:

Center for Independent Living (CIL)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The CIL must be an awardee of grant funding for independent living through the Administration for Community Living under the Rehabilitation Act of 1973, as amended.

At a minimum, the CIL must provide the following core services: Information and referral; Independent Living skills training; Peer counseling; Individual and systems advocacy; and Services that facilitate transition from nursing homes and other institutions to the community, assistance to those at risk of entering institutions, and facilitate the transition of youth to post-secondary life.

The CIL must be a consumer-controlled, community-based, cross-disability, non-residential, private nonprofit agency.

For this service, the department does not have specific standards for subcontracts or providers regarding training, 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 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 Community Transition 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 agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

Individuals delivering services are required to 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:

Family and Community Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Family and Community (F&C) Supports services build upon the therapies provided by mental health professionals, including In Home Family Therapy under this waiver. F&C services are provided in the home with the family or in the community with the individual; practicing and implementing those coping strategies identified by mental health therapists. Whereas In Home Family Therapy is a skilled therapeutic service, F&C is the practical application of the skills and interventions that will allow the family and individual to function more appropriately. An example of F&C: the provider teaches the individual appropriate social behavior by taking the individual to a fast food restaurant. The individual practices not acting out, eating with manners, and thanking the food service workers. Another example: The mental health professional has indicated that the individual should experiment with a variety of physical activities that could be used to de-escalate anxiety. The F&C provider takes the individual running, walking, or a driving range to find a good activity for the individual; and then works with the individual to initiate the activity when anxiety is triggered.

F&C services shall support the individual and the individual's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the individual's and the family's social and emotional strength. The emphasis in service shall focus on the individual and the development of needed skills and improving behaviors that are impacting the family dynamics. Services may be provided in the family home, foster family home, or in the community.

F&C services shall be provided under the recommendation and direction of a mental health professional who is part of the individual's interdisciplinary team pursuant to 441 IAC Chapter 83. Family and Community Support services shall incorporate recommended support interventions and activities, which may include the following:
1) Developing and maintaining a crisis support network for the individual and their family.
2) Modeling and coaching effective coping strategies for the individual's family members.
3) Building resilience to the stigma of serious emotional disturbance for the individual and their family.
4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community individuals.
5) Modeling and coaching the strategies and interventions identified in the individual's crisis intervention plan as defined in 441 IAC Chapter 24 for life situations with the individual's family and in the community.
6) Developing medication management skills.
7) Developing personal hygiene and grooming skills that contribute to the individual's positive self-image.
8) Developing positive socialization and citizenship skills.

Therapeutic resources may include books, training materials, and visual or audio media. The therapeutic resources shall be

identified as a need of the individual in the individual's authorized service plan and shall be used as part of the implementation and delivery of the Family and Community Support service.
1) The interdisciplinary team must identify the transportation or therapeutic resource as a support need.
2) The annual amount available for transportation and therapeutic resources must be listed in the individual's service plan.
3) The individual's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the individual or the individual's family or legal guardian.
4) The individual's IHH Care Coordinator shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.
5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

The following components are specifically excluded from Family and Community Support services:
1) Vocational services.
2) Prevocational Services.
3) Supported Employment services.
4) Room and board.
5) Academic services.
6) General supervision and consumer care.

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 services plan as needed.

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

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

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

The service shall be provided under the recommendation and direction of a mental health professional who is part of the member's interdisciplinary team. The service shall incorporate recommended support interventions and activities.

Excluded services and costs. Services, activities, costs, and time that are not covered include the following (not an exclusive list):
(1) Vocational services
(2) Prevocational Services
(3) Supported Employment services
(4) Room and board
(5) Academic services
(6) General supervision and consumer care

Persons in need of transportation within the community or to access identified therapeutic resources shall access the transportation service available under the waiver.

These services may not duplicate services provided under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) The services under this waiver are also 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 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 family training, 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 option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding

Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Mental Health Center
Agency	Behavioral Health Intervention Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family and Community Support

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):*

Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority. 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 Chapter 24. 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.

Staff training. The agency shall meet the following training requirements as a condition of providing Family and Community Support services under the Child and Youth waiver:
(1) Within one month of employment, staff members must receive the following training:
1. Orientation regarding the agency’s mission, policies, and procedures; and
2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77
(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
2. Confidentiality;
3. Provision of medication according to agency policy and procedure;
4. Identification and reporting of child abuse;
5. Incident reporting;
6. Documentation of service provision;
7. Appropriate behavioral interventions; and
8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.
(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.
(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

Staff within the enrolled organization must meet the following credentialing standards:
(1). Bachelor's degree in social sciences field plus additional experience or training or
(2). Bachelor's degree in non-social science field plus more additional experience or training

Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section135C.33(5)"a"(1) before employment of a staff member who will provide direct care.

As a condition of providing services, a Family and Community Support provider must:
(1) develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team
(2) have written policies and procedures for intake, admission, and discharge.

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: Family and Community Support

Provider Category:

Agency

Provider Type:

Behavioral Health Intervention Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies:
1. The Joint Commission accreditation (TJC), or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC), or

6. Iowa Administrative Code 441—Chapter 24, “Accreditation of Providers of Services to Persons with Mental Illness, Intellectual Disabilities, or Developmental Disabilities.”

Other Standard *(specify):*

Behavioral Health Intervention services providers qualified under 441.77.12 may provide Family and Community Support services when they meet the requirements below. A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is enrolled in the Iowa Plan for Behavioral Health pursuant to 441—Chapter 88, Division IV.

Staff training. The agency shall meet the following training requirements as a condition of providing Family and Community Support services under the Child and Youth waiver:
(1) Within one month of employment, staff members must receive the following training:
1. Orientation regarding the agency’s mission, policies, and procedures; and
2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77
(2) Within four months of employment, staff members must receive training regarding the following:
1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
2. Confidentiality;
3. Provision of medication according to agency policy and procedure;
4. Identification and reporting of child abuse;
5. Incident reporting;
6. Documentation of service provision;
7. Appropriate behavioral interventions; and
8. Professional ethics.
(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.
(4) Within the first year of employment, staff members must complete 24 hours of training in children’s mental health issues.
(5) During each consecutive year of employment, staff members must complete 12 hours of training in children’s mental health issues.

Staff within the enrolled organization must meet the following credentialing standards:
1. Bachelor’s degree in social sciences field plus additional experience or training or
2. Bachelor’s degree in non-social science field plus more additional experience or training
Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section135C.33(5)“a”(1) before employment of a staff member who will provide direct care.

Behavioral Health Intervention Services employees must:
1)Have a Bachelor’s degree in a social science field +
a)1 year experience OR
b)20 hours children’s mental health training
OR
2)Have a Bachelor’s degree in a social science field +
a)2 years experience OR
b)30 hours children’s mental health training

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

As a condition of providing services, a Family and Community Support provider must:
(a) develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441 Chapter 24 that is developed by each consumer’s interdisciplinary team
(b) have written policies and procedures for intake, admission, and discharge.

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 Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Covered Home and Vehicle Modifications are 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. 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) Turn around 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.

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

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

A unit of service is the completion of needed modifications or adaptations. The Home and Vehicle Modifications have an annual limit published on the Iowa Medicaid Fee Schedule website: https://hhs.iowa.gov/medicaid/provider-services/covered-services-rates-and-payments/fee-schedules, 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 listed 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 servicesand 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 option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Certified to Provide Supported Community Living
Agency	Area Agency on Aging or Subcontractor with AAA
Agency	Community Action Agency
Agency	Community Business
Agency	Enrolled Home or Vehicle Modification Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Agency Certified to Provide Supported Community Living

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 Modifications

Provider Category:

Agency

Provider Type:

Area Agency on Aging or Subcontractor with AAA

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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 five years

Appendix C: Participant Services

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

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

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 five years

Appendix C: Participant Services

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

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

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: Provider Specifications for Service

Service Type: Other Service

Service Name: Home and Vehicle Modifications

Provider Category:

Agency

Provider Type:

Enrolled Home or Vehicle Modification Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider that meets the requirements for home and vehicle modification provider pursuant to 441 IAC 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: 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-Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**

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

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

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

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

Service Definition *(Scope):*

Home-Delivered Meals are meals prepared elsewhere and delivered to a person's residence. Each meal shall ensure the person receives a minimum of one third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National of the National Research Council of the National Academy of Sciences. The meal may be a liquid supplement which meets the minimum one third daily dietary allowance standard. When a restaurant provides the home delivered meal, the person is required to have nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the person and explain what constitutes the minimum one third daily dietary allowance.

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 a meal. A maximum of 14 meals is allowed per week. The rates for allowable provider types are published in the Iowa Administrative Code. The rates are subject to change on a yearly basis.

Home Delivered Meals are provided to children and youth who require specialized exceptional care. 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.

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, such as Attendant Care, is the person's case manager. While Attendant Care may cover meal prep and clean up, Home Delivered Meals cover the cost of food which is not covered under any other waiver service. The case manager is responsible for the authorization and monitoring of services in a person's service plan. If the case manager requests authorization for similar services, they are responsible for ensuring that the services are delivered as written in the person centered service plan.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the

exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospital
Agency	Restaurant
Agency	Nursing Facility
Agency	Home Health Agency
Agency	Community Action Agency
Agency	Home Care Provider
Agency	Area Agency on Aging or Subcontractor with AAA
Agency	Assisted Living Programs
Agency	Medical Equipment Supply Dealer

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home-Delivered Meals

Provider Category:

Agency

Provider Type:

Hospital

Provider Qualifications

License *(specify):*

Enrolled as a Medicaid Provider in accordance with Iowa Code 135. 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) and are eligible to participate in the medical assistance program.

Certificate *(specify):*

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.

Other Standard *(specify):*

Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 2022 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to people that is safe, unadulterated, and honestly presented.

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: Home-Delivered Meals

Provider Category:

Agency

Provider Type:

Restaurant

Provider Qualifications

License *(specify):*

Licensed and inspected under Iowa Code Chapter 137F: A person shall not operate a food establishment or food processing plant to provide goods or services to the general public, or open a food establishment to the general public, until the appropriate license has been obtained from the regulatory authority. Sale of products at wholesale to outlets not owned by a commissary owner requires a food processing plant license. A license shall expire one year from the date of issue. A license is renewable.

The appropriate regulatory authority shall provide for the inspection of each food establishment and food processing plant in accordance with the Iowa Administrative Code. A regulatory authority may enter a food establishment or food processing plant at any reasonable hour to conduct an inspection. The manager or person in charge of the food establishment or food processing plant shall afford free access to every part of the premises and render all aid and assistance necessary to enable the regulatory authority to make a thorough and complete inspection. As part of the inspection process, the regulatory authority shall provide an explanation of the violation or violations cited and provide guidance as to actions for correction and elimination of the violation or violations.

Certificate *(specify):*

Other Standard *(specify):*

Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 2022 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to people that is safe, unadulterated, and honestly presented.

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: Home-Delivered Meals

Provider Category:

Agency

Provider Type:

Nursing Facility

Provider Qualifications

License *(specify):*

Licensed pursuant to 481 Iowa Administrative code Chapter 58 and qualifying for Medicaid enrollment as described in Iowa Administrative Code 441 Chapter 81.

Certificate *(specify):*

"Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483 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.

Other Standard *(specify):*

Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 2022 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to people that is safe, unadulterated, and honestly presented.

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: Home-Delivered Meals

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):*

Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 2022 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to people that is safe, unadulterated, and honestly presented.

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: Home-Delivered Meals

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 for monitoring service provision to ensure services are provided in a safe and effective manner.

Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 2022 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to people that is safe, unadulterated, and honestly presented.

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: Home-Delivered Meals

Provider Category:

Agency

Provider Type:

Home Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Home care providers that have a contract with 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):*

Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 2022 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to people that is safe, unadulterated, and honestly presented.

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: Home-Delivered Meals

Provider Category:

Agency

Provider Type:

Area Agency on Aging or Subcontractor with AAA

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Area agency on aging designated in accordance with Iowa Code 231 or home-delivered meals 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 home-delivered meals services.

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 for monitoring service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, 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-Delivered Meals

Provider Category:

Agency

Provider Type:

Assisted Living Programs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

For this service, the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience, or education than what would be contained in IAC 481-chapter 69. 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. Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 2022 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to people that is safe, unadulterated, and honestly presented.

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: Home-Delivered Meals

Provider Category:

Agency

Provider Type:

Medical Equipment Supply Dealer

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

Other Standard *(specify):*

Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 2022 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to people that is safe, unadulterated, and honestly presented.

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: Service Specification

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

Service Type:

Other Service

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

Service Title:

Medical Day Care for Children

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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 to avoid institutionalization, 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:
• 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.

The scope of the Medical Day Care for Children services exceeds the scope of the categories of mandatory and optional services listed in section 1905(a) and are medical services beyond typical day care responsibilities provided to children in traditional childcare settings.

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

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

A unit of service is 15 minutes. The 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. 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 residential or Respite services, such as attendant care. The services are limited to additional services not otherwise covered under the state plan, including childcare medical services and EPSDT, but consistent with waiver objectives of avoiding institutionalization.

The person’s case manager is responsible for oversight to avoid duplication of servicesand 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 option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	HCBS Respite Provider
Agency	Child Care Facility
Agency	Agency Certified to Provide Supported Community Living
Agency	Home Care 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 and is not the spouse of the person served or the parent or stepparent of a person aged 17 or under.

(2) Be qualified by training and experience to carry out the person's service plan pursuant to the department-approved service planning process. Training must occur during the first six weeks of employment and at a minimum must include:
• Serious emotional disturbance in children and service provision to children with serious emotional disturbance;
• Medical complexity in children and service provision to children with medical complexity;
• Implementing member person-centered service plans;
• Confidentiality;
• Provision of medication according to agency policy and procedure;
• Identification and reporting of child abuse;
• Incident reporting;
• Documentation of service provision;
• Appropriate behavioral interventions; and
• Professional ethics

(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:
• Training employees on member support needs.
• 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.
• Reporting minor and major incidents.
• Ensuring the safety and privacy of the individual.
• Emergencies. Policies shall at a minimum address the threat of fire, tornado, or flood, and bomb threats.
• Crisis response. Crisis response including behavioral and medical crisis.
• Appropriate behavior interventions.
• Appropriate medical interventions.

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: Medical Day Care for Children

Provider Category:

Agency

Provider Type:

HCBS Respite Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified to provide specialized respite by the Department's Home and Community Based Services Quality Oversight Unit as outlined in Iowa Administrative Code 441 Chapter 77.

Other Standard *(specify):*

Providers must:
(1) Ensure services are rendered by a person who is 18 years of age and is not the spouse of the person served or the parent or stepparent of a person aged 17 or under.

(2) Be qualified by training and experience to carry out the person's service plan pursuant to the department-approved service planning process. Training must occur during the first six weeks of employment and at a minimum must include:
• Serious emotional disturbance in children and service provision to children with serious emotional disturbance;
• Medical complexity in children and service provision to children with medical complexity;
• Implementing member person-centered service plans;
• Confidentiality;
• Provision of medication according to agency policy and procedure;
• Identification and reporting of child abuse;
• Incident reporting;
• Documentation of service provision;
• Appropriate behavioral interventions; and
• Professional ethics

(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:
• Training employees on member support needs.
• 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.
• Reporting minor and major incidents.
• Ensuring the safety and privacy of the individual.
• Emergencies. Policies shall at a minimum address the threat of fire, tornado, or flood, and bomb threats.

• Crisis response. Crisis response including behavioral and medical crisis.
• Appropriate behavior interventions.
• Appropriate medical interventions.

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 Chapter 109 or 110.

Certificate *(specify):*

Other Standard *(specify):*

Providers must:
(1) Ensure services are rendered by a person who is 18 years of age and is not the spouse of the person served or the parent or stepparent of a person aged 17 or under.

(2) Be qualified by training and experience to carry out the person's service plan pursuant to the department-approved service planning process. Training must occur during the first six weeks of employment and at a minimum must include:
• Serious emotional disturbance in children and service provision to children with serious emotional disturbance;
• Medical complexity in children and service provision to children with medical complexity;
• Implementing member person-centered service plans;
• Confidentiality;
• Provision of medication according to agency policy and procedure;
• Identification and reporting of child abuse;
• Incident reporting;
• Documentation of service provision;
• Appropriate behavioral interventions; and
• Professional ethics

(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:
• Training employees on member support needs.
• 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.
• Reporting minor and major incidents.
• Ensuring the safety and privacy of the individual.
• Emergencies. Policies shall at a minimum address the threat of fire, tornado, or flood, and bomb threats.
• Crisis response. Crisis response including behavioral and medical crisis.
• Appropriate behavior interventions.
• Appropriate medical interventions.

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:

Agency Certified to Provide Supported Community Living

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 chapter 77.

Other Standard *(specify):*

Providers must:
(1) Ensure services are rendered by a person who is 18 years of age and is not the spouse of the person served or the parent or stepparent of a person aged 17 or under.

(2) Be qualified by training and experience to carry out the person's service plan pursuant to the department-approved service planning process. Training must occur during the first six weeks of employment and at a minimum must include:
• Serious emotional disturbance in children and service provision to children with serious emotional disturbance;
• Medical complexity in children and service provision to children with medical complexity;
• Implementing member person-centered service plans;
• Confidentiality;
• Provision of medication according to agency policy and procedure;
• Identification and reporting of child abuse;
• Incident reporting;
• Documentation of service provision;
• Appropriate behavioral interventions; and
• Professional ethics

(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:
• Training employees on member support needs.
• 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.
• Reporting minor and major incidents.
• Ensuring the safety and privacy of the individual.
• Emergencies. Policies shall at a minimum address the threat of fire, tornado, or flood, and bomb threats.
• Crisis response. Crisis response including behavioral and medical crisis.
• Appropriate behavior interventions.
• Appropriate medical interventions.

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: Medical Day Care for Children

Provider Category:

Agency

Provider Type:

Home Care Provider

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 and is not the spouse of the person served or the parent or stepparent of a person aged 17 or under.
(2) Be qualified by training and experience to carry out the person's service plan pursuant to the department-approved service planning process. Training must occur during the first six weeks of employment and at a minimum must include:
• Serious emotional disturbance in children and service provision to children with serious emotional disturbance;
• Medical complexity in children and service provision to children with medical complexity;
• Implementing member person-centered service plans;
• Confidentiality;
• Provision of medication according to agency policy and procedure;
• Identification and reporting of child abuse;
• Incident reporting;
• Documentation of service provision;
• Appropriate behavioral interventions; and
• Professional ethics

(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:
• Training employees on member support needs.
• 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.

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: 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:

Peer Mentoring

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

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

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

Service Definition *(Scope):*

Peer Mentoring is provided by a peer who draws from common experience as a waiver participant, family member or caregiver to a participant, to support a person with acclimation to community living and maintaining community tenure. The peer supports the person by offering advice, guidance, and encouragement on matters of community living.
Matters of community living include but are not limited to:
• Problem-solving issues drawing from shared experience.
• Goal setting, self-advocacy, community acclimation and integration techniques.
• Assisting with interviewing potential providers, understanding complicated health and safety issues, and participating on private and public boards, advisory groups and commissions.
• Activities that promote interaction with friends and companions of choice.
• Teaching and modeling of social skills, communication, group interaction, and collaboration.
• Developing community relationships with the intent of building social capital that results in the expansion of opportunities to explore personal interests.
• Assisting the person in acquiring, retaining, and improving self-help, socialization, self-advocacy, and adaptive skills necessary for community living.
• Support for integrated and meaningful engagement and awareness of opportunities for community involvement including volunteering, self-advocacy, education options, and other opportunities identified by the individual.
• Assisting person to be aware of and engage in community resources.

To access Peer Mentorship, a person must participate in a needs assessment through which they demonstrate a need for the service based on the following:
• The person demonstrates a need for a peer to mentor acclimation to community living and assist with maintaining community tenure
• The person’s need demonstrates health, safety, or institutional risk; and
• There are no other services or resources available to meet the need; and
• The person demonstrates that, within 365 days, they have the ability to acquire these skills or establish other services or resources necessary to their need.

Peer Mentorship does not include services or activities that are solely diversional or recreational in nature.

Telehealth is an allowable mode for delivering this service. The purpose of the telehealth option in this service is to maintain and/or improve a person’s ability to support relationships while also encouraging and promoting their ability to participate in the 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.

“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 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:

The unit is 15 minutes. Peer Mentorship is available up to 16 units (four hours) a day for up to a period of 365 days following the initial service date.

Peer mentoring may be delivered in a one-to-one or in a group of no more than three HCBS members.

Excluded services and costs. Services, activities, costs, and time that are not covered and for which payment shall not be made for:
(1) Purchasing or installation of telehealth equipment or technologies
(2) Peer mentoring provided by the person’s family member(s)
(3) Activities that are solely diversional or recreational in nature

Providers of this service do not provide case management services to a person on the waiver, nor do providers of this service have the ability to determine of level of care, functional or financial eligibility for services or provide person-centered service planning.

The person’s case manager is responsible for the authorization and monitoring of services in a person’s service plan. The case manager is responsible for oversight to avoid duplication of services and to assure state plan services and other services such as B3 mental health and substance use disorder 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.

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 option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Certified to Provide Supported Community Living
Agency	Center for Independent Living (CIL)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Peer Mentoring

Provider Category:

Agency

Provider Type:

Agency Certified to Provide Supported Community Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers certified by the HCBS Quality Improvement Organization to provide Supported Community Living pursuant to Iowa Administrative Code 441 Chapter 77.

Other Standard *(specify):*

Providers must:
(1) Ensure services are rendered by a person who is 18 years of age 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 peer mentoring 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 agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

Peer Mentorship is provided by a peer who draws from common experience as a waiver participant, family member or caregiver to a to support an individual with acclimating to community living and maintaining community tenure. The provider must ensure services are delivered by a peer mentor staff who:
(1) Has lived experience transferable to support a client in acclimating to community living through providing them client advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the client's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving;
(2) Is qualified in the customized needs of the client as described in the person-centered service plan.
(3) Has completed the provider agency's peer mentor training, which is to be consistent with core competencies as defined by HHS.

Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Health and Human Services, Iowa Medicaid, 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: Peer Mentoring

Provider Category:

Agency

Provider Type:

Center for Independent Living (CIL)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The CIL must be an awardee of grant funding for independent living through the Administration for Community Living under the Rehabilitation Act of 1973, as amended.

At a minimum, the CIL must provide the following core services: Information and referral; Independent Living skills training; Peer counseling; Individual and systems advocacy; and Services that facilitate transition from nursing homes and other institutions to the community, assistance to those at risk of entering institutions, and facilitate the transition of youth to post-secondary life.

The CIL must be a consumer-controlled, community-based, cross-disability, non-residential, private nonprofit agency.

Providers must:
(1) Ensure services are rendered by a person who is 18 years of age 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 Peer Mentoring 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 agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

Peer Mentoring is provided by a peer who draws from common experience as a waiver participant, family member or caregiver to a to support an individual with acclimating to community living and maintaining community tenure. The provider must ensure services are delivered by a peer mentor staff who:
(1) Has lived experience transferable to support a client in acclimating to community living through providing them client advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the client's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving;
(2) Is qualified in the customized needs of the client as described in the service Plan.
(3) Has completed the provider agency's peer mentor training, which is to be consistent with core competencies as defined by the Department.

Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System or Portable Locator System

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

A Personal Emergency Response System is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency. The necessary components of a system are:
1) An in-home medical communications transceiver.
2) A remote, portable activator.
3) A central monitoring station with backup systems staffed by trained attendants at all times.
4) Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each 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, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

A unit of service is a one-time installation fee or month of service. Maximum units per state fiscal year shall be one initial installation and 12 ongoing monthly units of service.

The person's case manager is responsible for oversight to avoid duplication of servicesand 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 option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency Response System Provider
Agency	Assisted Living Programs

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 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 Programs

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

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

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

Service Definition *(Scope):*

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.

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.

Evidence-based practices include implementation in a data-based manner using culturally relevant and representative assessment and intervention to drive and monitor practices and make decisions for improvement.

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.

"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.

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 a 15-minute unit.

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.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Mental Health Center
Agency	Mental Health Service Provider
Agency	Home Health Agency
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	Agency Certified to Provide Supported Community Living
Individual	Mental Health Service Professional

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):*

Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority. 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 Chapter 77. 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 77 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.
(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 24and 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 Chapter 77. 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 77 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:

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 Chapter 77. 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 77 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 Chapter 77. 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 77 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:

Agency Certified to Provide Supported Community Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

SCL Providers Certified Under IAC 441 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 Chapter 77. 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 77 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:

Individual

Provider Type:

Mental Health Service 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 Chapter 24. 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: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Transportation services may be provided for 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 medical services; this service is offered in addition to medical transportation required under 42 CFR Section 431.53 and transportation services under the State plan defined at 42 CFR 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 needs.

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 a one mile, one one-way trip.

Transportation may not be reimbursed simultaneously with any other transportation service 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).

The person's case manager is responsible for oversight to avoid duplication of servicesand 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 person-centered 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.

Members ages 16+ (or otherwise emancipated) can ride alone. Those who are 12 to 15 years of age can ride alone if they have a signed parent or guardian waiver. Minor parents (under 18 years of age) who are attending their child's medical appointment may travel alone. All other minor members must be accompanied by an adult at least 21 years old.

Persons enrolled in the waiver have access to Iowa's Waiver of Administrative Rules option. Waiver of Administrative Rules 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 Waiver of Administrative Rules. The request must substantiate the exceptional need and also address why no other Medicaid or waiver service can address the issue. Decisions regarding Waiver of Administrative Rules requests are approved by the Department of Health and Human Services director.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Area Agency on Aging or Subcontractor with AAA
Agency	NEMT Provider
Agency	Nursing Facility
Agency	Community Action Agency
Agency	Regional Transit Agency
Agency	Agency Certified to Provide Supported Community Living

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 or Subcontractor with AAA

Provider Qualifications

License *(specify):*

Enrolled provider 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 agency 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. An AAA must request prior approval from the department of any proposed service contracts with for-profit 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 at 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 demonstrates that the for-profit organization can provide services that are consistent with the goals of the AAA as stated in the area plan.

All drivers:
1. Must Possess a current valid driver's license with no restrictions other than corrective lenses.
2. Must have no limitation or restrictions that would interfere with safe driving. This includes, but not limited to, medical conditions, ignition interlock restriction, or prescribed medication that would interfere with the safe, lawful operation of a motor Vehicle.
3. Must pass a background check prior to the start of employment.
4. Must pass a child and dependent adult abuse background check.
5. Must be trained in Basic Red Cross or equivalent training in First Aid and Cardiopulmonary Resuscitation (CPR).
6. Must be trained in the use of ADA access equipment, if Vehicle is so equipped.
7. Must use passenger restraint devices as required by law.
8. Must provide assistance to passengers, as needed or requested, particularly for passengers with mobility impairments requiring assistance in boarding, deboarding, or securing a mobility device.
9. Must not smoke while transporting Members.
10. Must not transport Members while under the influence of alcohol or any drug that impairs the ability to drive safely.
11. Must not provide transportation if they have an illness that could pose a threat to the health and wellbeing of the Member.

All Vehicles:
1. Must have current license and registration as required by law.
2. Must have proof of financial responsibility maintained on any Vehicle used to transport Iowa Medicaid Members as required by law.
3. Must be kept at all times in proper mechanical condition.
4. Must have adequately functioning heating and air-conditioning systems and shall maintain a temperature at all times that is comfortable to the Member.
5. Must be equipped with operable passenger restraint devices, turn signals, lights, horn, brakes, a front and rear windshield, windows, and mirrors.
6. Must pass a safety inspection, if required by state or federal law.
7. Must carry equipment for two-way emergency communication (two-way radio or cell phone acceptable).

For this service, the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience, or education beyond those implemented by the contracting agency. Contracting agencies are responsible 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:

NEMT Provider

Provider Qualifications

License *(specify):*

Enrolled provider 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 is in good standing with and participating in Iowa Medicaid's NEMT program under Iowa Administrative Code 441.78.13.

All drivers:
1. Must Possess a current valid driver's license with no restrictions other than corrective lenses.
2. Must have no limitation or restrictions that would interfere with safe driving. This includes, but not limited to, medical conditions, ignition interlock restriction, or prescribed medication that would interfere with the safe, lawful operation of a motor Vehicle.
3. Must pass a background check prior to the start of employment.
4. Must pass a child and dependent adult abuse background check.
5. Must be trained in Basic Red Cross or equivalent training in First Aid and Cardiopulmonary Resuscitation (CPR).
6. Must be trained in the use of ADA access equipment, if Vehicle is so equipped.
7. Must use passenger restraint devices as required by law.
8. Must provide assistance to passengers, as needed or requested, particularly for passengers with mobility impairments requiring assistance in boarding, deboarding, or securing a mobility device.
9. Must not smoke while transporting Members.
10. Must not transport Members while under the influence of alcohol or any drug that impairs the ability to drive safely.
11. Must not provide transportation if they have an illness that could pose a threat to the health and wellbeing of the Member.

All Vehicles:
1. Must have current license and registration as required by law.
2. Must have proof of financial responsibility maintained on any Vehicle used to transport Iowa Medicaid Members as required by law.
3. Must be kept at all times in proper mechanical condition.
4. Must have adequately functioning heating and air-conditioning systems and shall maintain a temperature at all times that is comfortable to the Member.
5. Must be equipped with operable passenger restraint devices, turn signals, lights, horn, brakes, a front and rear windshield, windows, and mirrors.
6. Must pass a safety inspection, if required by state or federal law.
7. Must carry equipment for two-way emergency communication (two-way radio or cell phone acceptable).

For this service, the department does not have other 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. The NEMT broker(s) are responsible for ensuring that the provider of transportation is qualified, trained, 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 Facility

Provider Qualifications

License *(specify):*

Licensed pursuant to Iowa Code Chapter 135C and qualifying for Medicaid enrollment as described in Iowa Administrative Code 441 Chapter 77.

Enrolled provider 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):*

“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.

Other Standard *(specify):*

All drivers:
1. Must Possess a current valid driver’s license with no restrictions other than corrective lenses.
2. Must have no limitation or restrictions that would interfere with safe driving. This includes, but not limited to, medical conditions, ignition interlock restriction, or prescribed medication that would interfere with the safe, lawful operation of a motor Vehicle.
3. Must pass a background check prior to the start of employment.
4. Must pass a child and dependent adult abuse background check.
5. Must be trained in Basic Red Cross or equivalent training in First Aid and Cardiopulmonary Resuscitation (CPR).
6. Must be trained in the use of ADA access equipment, if Vehicle is so equipped.
7. Must use passenger restraint devices as required by law.
8. Must provide assistance to passengers, as needed or requested, particularly for passengers with mobility impairments requiring assistance in boarding, deboarding, or securing a mobility device.
9. Must not smoke while transporting Members.
10. Must not transport Members while under the influence of alcohol or any drug that impairs the ability to drive safely.
11. Must not provide transportation if they have an illness that could pose a threat to the health and wellbeing of the Member.

All Vehicles:

1. Must have current license and registration as required by law.
2. Must have proof of financial responsibility maintained on any Vehicle used to transport Iowa Medicaid Members as required by law.
3. Must be kept at all times in proper mechanical condition.
4. Must have adequately functioning heating and air-conditioning systems and shall maintain a temperature at all times that is comfortable to the Member.
5. Must be equipped with operable passenger restraint devices, turn signals, lights, horn, brakes, a front and rear windshield, windows, and mirrors.
6. Must pass a safety inspection, if required by state or federal law.
7. Must carry equipment for two-way emergency communication (two-way radio or cell phone acceptable).

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. The NEMT contractor agencies are responsible for ensuring that the contractor is qualified, trained, and reliable.

Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License *(specify):*

Enrolled provider 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):*

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

All drivers:
1. Must Possess a current valid driver’s license with no restrictions other than corrective lenses.
2. Must have no limitation or restrictions that would interfere with safe driving. This includes, but not limited to, medical conditions, ignition interlock restriction, or prescribed medication that would interfere with the safe, lawful operation of a motor Vehicle.
3. Must pass a background check prior to the start of employment.
4. Must pass a child and dependent adult abuse background check.
5. Must be trained in Basic Red Cross or equivalent training in First Aid and Cardiopulmonary Resuscitation (CPR).
6. Must be trained in the use of ADA access equipment, if Vehicle is so equipped.
7. Must use passenger restraint devices as required by law.

8. Must provide assistance to passengers, as needed or requested, particularly for passengers with mobility impairments requiring assistance in boarding, deboarding, or securing a mobility device.
9. Must not smoke while transporting Members.
10. Must not transport Members while under the influence of alcohol or any drug that impairs the ability to drive safely.
11. Must not provide transportation if they have an illness that could pose a threat to the health and wellbeing of the Member.

All Vehicles:
1. Must have current license and registration as required by law.
2. Must have proof of financial responsibility maintained on any Vehicle used to transport Iowa Medicaid Members as required by law.
3. Must be kept at all times in proper mechanical condition.
4. Must have adequately functioning heating and air-conditioning systems and shall maintain a temperature at all times that is comfortable to the Member.
5. Must be equipped with operable passenger restraint devices, turn signals, lights, horn, brakes, a front and rear windshield, windows, and mirrors.
6. Must pass a safety inspection, if required by state or federal law.
7. Must carry equipment for two-way emergency communication (two-way radio or cell phone acceptable).

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Regional Transit Agency

Provider Qualifications

License *(specify):*

Enrolled provider 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):*

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 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.

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 schedules;
(3) Ensure that drivers must possess commercial driver's license; 4) ensure that employees pass routine drug and alcohol testing.

All individuals providing transportation must possess the following qualifications:
(1) Hold an active commercial driver's license (Iowa Code 321.88).
(2) Routinely pass drug and alcohol testing.
(3) Undergo training consistent with the policies of the Office of Public Transit.

All drivers:
1. Must Possess a current valid driver’s license with no restrictions other than corrective lenses.
2. Must have no limitation or restrictions that would interfere with safe driving. This includes, but not limited to, medical conditions, ignition interlock restriction, or prescribed medication that would interfere with the safe, lawful operation of a motor Vehicle.
3. Must pass a background check prior to the start of employment.
4. Must pass a child and dependent adult abuse background check.
5. Must be trained in Basic Red Cross or equivalent training in First Aid and Cardiopulmonary Resuscitation (CPR).
6. Must be trained in the use of ADA access equipment, if Vehicle is so equipped.
7. Must use passenger restraint devices as required by law.
8. Must provide assistance to passengers, as needed or requested, particularly for passengers with mobility impairments requiring assistance in boarding, deboarding, or securing a mobility device.
9. Must not smoke while transporting Members.
10. Must not transport Members while under the influence of alcohol or any drug that impairs the ability to drive safely.
11. Must not provide transportation if they have an illness that could pose a threat to the health and wellbeing of the Member.

All Vehicles:
1. Must have current license and registration as required by law.
2. Must have proof of financial responsibility maintained on any Vehicle used to transport Iowa Medicaid Members as required by law.
3. Must be kept at all times in proper mechanical condition.
4. Must have adequately functioning heating and air-conditioning systems and shall maintain a temperature at all times that is comfortable to the Member.
5. Must be equipped with operable passenger restraint devices, turn signals, lights, horn, brakes, a front and rear windshield, windows, and mirrors.
6. Must pass a safety inspection, if required by state or federal law.
7. Must carry equipment for two-way emergency communication (two-way radio or cell phone acceptable).

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:

Agency Certified to Provide Supported Community Living

Provider Qualifications

License *(specify):*

Enrolled provider 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 Quality Improvement Organization 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, other than what would be contained in statute or administrative rules for this provider. Providers are responsible for ensuring that the contractor is qualified, trained, and reliable.

All drivers:
1. Must Possess a current valid driver's license with no restrictions other than corrective lenses.
2. Must have no limitation or restrictions that would interfere with safe driving. This includes, but not limited to, medical conditions, ignition interlock restriction, or prescribed medication that would interfere with the safe, lawful operation of a motor Vehicle.
3. Must pass a background check prior to the start of employment.
4. Must pass a child and dependent adult abuse background check.
5. Must be trained in Basic Red Cross or equivalent training in First Aid and Cardiopulmonary Resuscitation (CPR).
6. Must be trained in the use of ADA access equipment, if Vehicle is so equipped.
7. Must use passenger restraint devices as required by law.
8. Must provide assistance to passengers, as needed or requested, particularly for passengers with mobility impairments requiring assistance in boarding, deboarding, or securing a mobility device.
9. Must not smoke while transporting Members.
10. Must not transport Members while under the influence of alcohol or any drug that impairs the ability to drive safely.
11. Must not provide transportation if they have an illness that could pose a threat to the health and wellbeing of the Member.

All Vehicles:
1. Must have current license and registration as required by law.
2. Must have proof of financial responsibility maintained on any Vehicle used to transport Iowa Medicaid Members as required by law.
3. Must be kept at all times in proper mechanical condition.
4. Must have adequately functioning heating and air-conditioning systems and shall maintain a temperature at all times that is comfortable to the Member.
5. Must be equipped with operable passenger restraint devices, turn signals, lights, horn, brakes, a front and rear windshield, windows, and mirrors.
6. Must pass a safety inspection, if required by state or federal law.
7. Must carry equipment for two-way emergency communication (two-way radio or cell phone acceptable).

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 §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☒ **As an administrative activity.** *Complete item C-1-c.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Targeted case managers (TCM) or case managers provide case management services to fee-for- service participants and MCO community-based case managers (CBCMs) provide case management services to MCO enrolled participants enrolled in the state's Children and Youth waiver. All individuals providing case management services have knowledge of community alternatives and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of individuals served.

Case managers are expected to ensure that contacts with members occur as frequently as necessary and that they are conducted and documented consistent with the following:
1) Case Management services are delivered pursuant to 441 IAC chapter 90.
2) Case Managers must have at least one face-to-face contact per month for the first three months of enrollment. This requirement applies when a case management-eligible individual newly enrolls with Case Management or when an existing individual first becomes eligible for Case Management.
3) Following the first three months, the Case Manager must complete at least one contact per month with the individual or their authorized representative.
(4) Individuals who are authorized to receive HCBS services who have been diagnosed with an Intellectual and/or Developmental Disability, the Case Manager must complete at least one, in-home, face-to-face contact every other month.
(5) 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.

Case Managers must complete an initial Case Manager (CM) Certification within six months of their hire date and are required to complete the CM Refresher, which is a subset of the CM Certification, annually within 365 days of completion. The HCBS settings regulations and person-centered planning practice are modules within the certification and recertification.

Case management services are delivered in a conflict free manner consistent with Balancing Incentive Program requirements. HHS approves and monitors all MCO policies and procedures to ensure compliance.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), if the provider is regulated by the state or receives any state or federal funding, prospectives employees must complete child abuse, dependent adult abuse and criminal background screenings before employment if the prospective employee will provide 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.

HCBS providers are also screened in accordance with the requirements of 42 CFR Part 455 Subpart E Provider Screening and Enrollment as applicable to the provider type enrolling or reenrolling to deliver HCBS.

As part of the provider’s self-assessment and certification 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 QIO 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. HHS also completes any evaluation needed for screenings returned with records or charges. Background checks only include Iowa unless the applicant is a resident of another state providing services in Iowa.

MCOs are contractually required to assure that all persons, whether they are employees, agents, subcontractors, or anyone acting for or on behalf of the MCO, are properly licensed, certified, or accredited as required under applicable state law and the Iowa Administrative Code. The Contractor shall provide standards for service providers who are not otherwise licensed, certified, or accredited under state law or the Iowa Administrative Code.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Iowa Code 135C. 33 (5)(a)(1) and (5)(a)(3) outlines requirement for abuse registry and screening. If the provider is regulated by the state or receives any state or federal funding, prospective employees must complete child abuse, dependent adult abuse and criminal background screenings before employment if the prospective employee will provide 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 and criminal background checks prior to employment with a member. The Fiscal Management provider completes the child and dependent adult abuse and criminal background checks. The employee shall not be paid for any services to the member prior to the completion of the checks. 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 the CCO member.

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 and certification 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 HCBS QIO 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. HHS also completes any evaluation needed for screenings returned with records or charges. MCOs are also required to ensure that all required screening is conducted for providers who are not employees of a provider agency or licensed/accredited by a board that conducts background checks (i.e., non-agency affiliated self-direction service

providers). HHS retains final authority to determine if an employee may work in a particular program.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

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

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

A person who is legally responsible for a member may provide services to a waiver member. This applies to spouses, guardians of their adult children or of other adults, age 18 or older, for whom they have been legally appointed as the guardian. Parents and guardians of members aged 17 and younger may also be paid providers of service. The person who is legally responsible for a member may be an employee or subcontractor, an agency provider, or an employee under the Consumer Choices Option (CCO) program and provide the services listed as approved in the Participant-directed person-centered service plan. When the legally responsible person delivers services, 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 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 case manager or 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 person-centered service plan that is authorized and monitored by a case manager or 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. HHS maintains oversight of the MCO program integrity plans and responsibility for overall quality monitoring and oversight.

☒ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

A member's relative or legal representative may provide services to a member. Payments may be made to any relative, or in some circumstances, a legal representative of the member that 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 a provider agency. When the legal representative delivers services, 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.

The rate of pay and the care provided by the member's relative or legal representative 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 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. 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 Unit markets provider enrollment for Iowa Medicaid. Potential providers may access an application online 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, market to qualified providers to enroll in Medicaid.

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the 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:
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	Frequency of data	Sampling Approach

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Contracted entity	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Contracted entity	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
QP-b1: Number and percent of non-licensed/noncertified providers that met waiver requirements prior to direct service delivery. Numerator = # of non-

licensed/noncertified providers who met waiver requirements prior to direct service delivery; Denominator = # of non-licensed/noncertified providers.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Contracted entity	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
QP-b2: Number and percent of Consumer Choice Option (CCO) providers that met waiver requirements prior to direct service delivery. Numerator = number of CCO providers who met waiver requirements prior to direct service delivery Denominator = number of CCO providers

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

Contracted entity		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP-c1: Number and percent of HCBS providers that meet training requirements as outlined in State regulations and the approved waiver. Numerator = # of HCBS providers that meet training requirements as outlined in State regulations and the approved waiver; Denominator = # of HCBS providers that had a certification or periodic quality assurance review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider's evidence of staff training and provider training policies. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Contracted entity	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

The Iowa Medicaid Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment.

All MCO providers must be enrolled as verified by Iowa Medicaid Provider Services.

The Home and Community Based Services (HCBS) QIO 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. In addition, provide information on the methods used by the state to document these items.

If it is discovered by the 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 makes these corrections, they are ineligible to provide services to waiver members. All MCO providers must be enrolled as verified by Iowa Medicaid Provider Services. If the provider is no longer enrolled by Iowa Medicaid then that provider is no longer eligible to enroll with an MCO. If it is discovered during an HCBS QIO provider oversight review that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated is noncompliance persists. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and required changes in individual provider policy.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☒ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Monthly service spending caps apply to all waiver members and waiver services with the following exceptions:
• Home and Vehicle Modifications
• Specialized Medical Equipment
• Supported Employment
• Community Transition Services

Waiver members are assigned a monthly service spending cap based on their assessed level of care (LOC). Each LOC has a monthly service spending cap maximum.
• Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-ID)
• Nursing Facility (NF)
• Skilled Nursing Facility (SNF)
• Hospital (HOSP)

Monthly service spending caps are documented as part of the members' person-centered service plan and updated with each assessment. Adjustments to monthly service spending caps must be reviewed and approved by Iowa Medicaid staff. A detailed breakdown of budget categories may be provided to CMS or other stakeholders upon request.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

HCBS services can be provided in the following settings:

-Individual member's homes of any type (houses, apartments, condominiums, etc.).
-Members living in their family home of any type. -Integrated community rental properties available to anyone within the community.
-Nonresidential Habilitation services including Prevocational Services and Supported Employment services that occur in integrated community-based settings.
-Adult Day Health may occur in the member's home or in integrated community-based settings.
-Respite may be temporarily provided in a licensed facility when the member requires Specialized Respite Care outside the home.

Provider-owned or controlled residential settings including:
-DIAL licensed Residential Care Facility (RCF)
-DIAL licensed Assisted Living Facility
-SCL provider agency subcontracted Host Home
-SCL provider agency daily site

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

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

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

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

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

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

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

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

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

HCBS may not be provided in settings that are presumed to have institutional qualities and do not meet the rule's requirements

for home and community-based settings. These settings include those in a publicly or privately-owned facility that provide inpatient treatment, on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.