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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information (1 of 3)

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

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

Children and Youth Waiver

C. Type of Request: new

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

○ **3 years** ◉ **5 years**

☒ **New to replace waiver**

Replacing Waiver Number:

IA0213, IA0345, IA0819, IA4111

Base Waiver Number:

Amendment Number (if applicable):

Effective Date: (mm/dd/yy)

Draft ID: **IA.023.00.00**

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

Regular Waiver

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

10/01/26

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so

that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

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

1. Request Information (2 of 3)

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

☒ **Hospital**

Select applicable level of care

◉ **Hospital as defined in 42 CFR § 440.10**

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☒ **Nursing Facility**

Select applicable level of care

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

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

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

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

☒ **Waiver(s) authorized under section 1915(b) of the Act.**

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

The 1915(b) Iowa High Quality Healthcare Initiative was originally approved with an effective date of April 1, 2016, and was last amended effective February 28, 2024.

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

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

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

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

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

☐ **A program operated under section 1932(a) of the Act.**

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

☐ **A program authorized under section 1915(i) of the Act.**

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

☐ **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Iowa HOME Children and Youth waiver's purpose is to ensure that young people in Iowa have access to high-quality behavioral health, disability, and developmental services in their communities. A goal of the waiver is to maximize positive outcomes for people who need waiver services, their caregivers, and providers. The Iowa Department of Health & Human Services (HHS) is the single state agency responsible for the oversight of Medicaid.

Applicants may access waiver services by submitting an application to HHS. Iowa HHS' Eligibility Benefit Specialists determine if the member is eligible for Medicaid. Iowa Medicaid's Core Standardized Assessment vendor completes the initial assessment and annual reassessment tools. The Iowa Medicaid's Quality Improvement Organization (QIO) Medical Services Unit contractor determines if the member meets the Level of Care (LOC) criteria initially and annually thereafter.

MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. In the event there is a waiting list for waiver services at the time of application to the waiver, applicants are advised of the waiting list and that they may choose to receive facility-based services. The waitlist includes a prioritization system to ensure that Iowans with the highest need can access services in a timely fashion.

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

The following services are provided under this waiver:
1) Services supporting daily activities and care: Home Delivered Meals, Respite, Transportation
2) Services helping with health needs: Positive Behavioral Support and Consultation and Family and Community Support
3) Equipment and modifications: Assistive Devices, Home and Vehicle Modifications, Personal Emergency Response System
4) Day services: Prevocational Services, Supported Employment, Medical Day Care for Children
5) Self direction supports: Financial Management Services, Independent Support Broker, Individual Goods and Services
6) Other services: Community Transition Services and Peer Mentoring

3. Components of the Waiver Request

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

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

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

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected

frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

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

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

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

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

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

HHS seeks continuous and ongoing public input through a variety of modalities, including townhalls, listening sessions, committees, and workgroups. Iowa Medicaid also participates and collaborates with a number of provider and member associations and advocacy groups.

Iowa Medicaid created supplemental public input venues to share updates and solicit input on potential changes to the waiver: (1) formed a steering committee comprised of Medicaid members and Medicaid providers to advise Iowa Medicaid (March 2023-present), (2) surveyed Medicaid members, caregivers, Medicaid providers and case managers on their experiences with community-based services (July 2023), (3) interviewed case managers (July-August, 2023), (4) interviewed individuals on the waiver waitlist (August-September 2023), (5) convened 12 in-person and three virtual public meetings (HOMEtown Conversations October – December 2023), (6) conducted voluntary screenings of individuals on the waiver waitlist (January-June 2024), (7) provided updates and solicited question during Medicaid townhalls with Medicaid members and Medicaid providers (March, May 2024), (8) published on the Iowa Medicaid website and emailed the concept paper that outlined proposed changes, (9) convened three virtual public listening sessions with Medicaid members and Medicaid providers to gather direct feedback on the proposed changes outlined in the concept paper (May 2024), (10) conducted focus groups on additional support needs (May-July 2024); and (11) conducted focus groups on system navigation (July 2024).

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

Iowa Medicaid used the following processes to secure public input into the development of the Children and Youth (CY) Waiver application:

1) Iowa Medicaid Website Posting – Will insert link to public notice from website

2) Iowa Medicaid Public Notice Subscribers - Medicaid members, Medicaid providers, legislators, advocacy organizations and others who wish to remain informed regarding Iowa Medicaid can subscribe to the Iowa Medicaid Public Notice webpage. All subscribers, including those subscribed to Iowa’s HOME contact list, will receive electronic notice whenever an update/public notice is posted. This process includes HCBS waiver applications. The public posting period was the same for this process. The public notice period began on MONTH DATE, 2026 and closed on MONTH DATE, 2026.

[SUMMARIZE PUBLIC COMMENTS]

4) Iowa Tribal Nations Notification - The Tribal Nations were notified of this new waiver via email MONTH DATE, 2026. The comment period remained open through MONTH DATE, 2026.

[SUMMARIZE Tribal COMMENTS]

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

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

7. Contact Person(s)

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

Last Name: Casey

First Name: Christy

Title: Program Manager

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

Address: 321 E 12th St.

Address 2: 321 E 12th St.

City: Des Moines, IA

State: **Iowa**

Zip: 50319

Phone: (515) 630-9649 **Ext:** ☐ **TTY**

Fax: (515) 725-1360

E-mail: christy.casey@hhs.iowa.gov

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

Last Name: McGuire

First Name: Latisha

Title: Federal Compliance Officer

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

Address: 321 E 12th St.

Address 2:

City: Des Moines

State: **Iowa**

Zip:

50319

Phone:

(515) 829-5627 **Ext:** ☐ **TTY**

Fax:

(515) 725-1360

E-mail:

latisha.mcguire@hhs.iowa.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

Grossman

First Name:

Lee

Title:

Medicaid Director

Agency:

Iowa Department of Health and Human Services/Iowa Medicaid

Address:

321 E 12th St.

Address 2:

321 E 12th St.

City:

Des Moines

State: **Iowa**

Zip:

50319

Phone:

(515) 380-1785 **Ext:** ☐ **TTY**

Fax:

(515) 725-1360

E-mail:

Lee.Grossman@hhs.iowa.gov

Attachments

Attachment #1: Transition Plan

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

- ☒ **Replacing an approved waiver with this waiver.**
- ☒ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☒ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☒ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☒ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☒ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Iowa will move from six disability-based waivers to two HOME waivers – the Children and Youth (CY) waiver and the Adult and Disability (AD) waiver. Iowa HHS has conducted extensive engagement across this effort, called Hope and Opportunities in Many Environments (HOME), to provide education on waiver goals and inform person-centered enhancements. Waiver services and coverage policies have been aligned with those previously available to members of Iowa's existing 1915(c) waivers.

Overview of the Children and Youth Waiver and Adult and Disability Waivers
On October 1, 2026, Iowa will begin transitioning from six diagnosis-based 1915(c) waivers into a CY waiver serving members through age twenty and an AD waiver serving those age twenty-one and older. On October 1, 2026, members currently enrolled in the Children's Mental Health (CMH), Health and Disability (HD), Physical Disability (PD), and AIDS/HIV waivers will transition to the CY or AD waivers. Iowa anticipates that members enrolled in the remaining two disability-based waivers, Brain Injury (BI) and Intellectual Disability (ID), will transition at a later date in 2027. The current 1915(c) Elderly waiver will remain unchanged. There is not a planned reduction in the number of current participants because of this waiver restructuring and consolidation. Current waiver members on the CMH, HD, PD, or AIDS/HIV waivers will be deemed eligible for the CY or AD waiver based on their age as of October 1, 2026.

Eligibility
Financial eligibility for the two new waivers is the same as the six diagnosis-based waivers. Clinical eligibility criteria for two new waivers is the same as the six diagnosis-based waivers. To meet the functional eligibility requirements for the Children and Youth waiver, members need a level of care provided in: an inpatient psychiatric facility, hospital (a psychiatric medical institution for children (PMIC)), an intermediate care facility for people with intellectual disabilities (ICF/ID), a nursing facility (NF), or a skilled nursing facility (SNF). To meet the functional eligibility requirements for the AD waiver, members need a level of care provided in: a NF, a SNF or an ICF/ID.

All persons served in one of the six 1915(c) waivers will be eligible for the new CY or AD waivers. The age limit of 21 was selected so that the CY waiver complements and does not duplicate services available to children through the state plan under the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit.

Based on community input and data on service use, Iowa HHS created service packages from which members can access services based on their needs and are not limited based on their specific diagnosis or disability. Iowa HHS developed service packages that retain existing services, add services to meet unmet needs, simplify administration, and eliminate duplication across services available. For services with limits that vary under current waivers, the highest current limit will be carried forth into the two new waivers, ensuring no reduction in service.

Transition Pathways

Members enrolled on a waitlist for an HCBS waiver before October 1, 2026, will move to a waitlist for one of the new waivers, based on their age on October 1, 2026. The waitlist will be based on the application date and those with the highest needs according to the results of the Waiver Priority Needs Assessment (WPNA).

All members enrolled in the CMH, HD, PD, and AIDS/HIV HCBS waivers before October 1, 2026, will transition to either the CY waiver or AD waiver on October 1, 2026 and continue to receive HCBS services as specified in their existing person-centered service plan. Prior to October 1, 2026, members will discuss continuity of care with their case managers and person-centered service plans will be updated for merged or removed services to ensure no gap in service access and no negative impact on the health and welfare of members receiving services. Member's will receive written notification of the move to the CY or the AD waiver no less than thirty days prior to the change which will include instruction on how to request a State Fair Hearing.

Level-of-care determinations will follow members onto the new waivers. Members will be re-assessed and have their service plan updated in accordance with their annual schedule.

Members pending HCBS waiver enrollment before October 1, 2026, will be transitioned to pending enrollment for their newly applicable HCBS waiver. All children turning 21, and wishing to transition to the AD waiver, in 2026 with a pending waiver slot or on a waiver waiting list will be contacted six months prior to implementation of the new waivers and notified to begin the disability determination process if applicable due to the AD waiver requiring disability for eligibility.

Members newly in need of HCBS services beginning October 1, 2026, will apply for the new waivers, using the Medicaid application. Members who do not have Medicaid will fill out the full Medicaid application. On October 1, 2026, members entering a waitlist for the two new waivers will have the option to be screened to determine their risk of being placed in an

institution using WPNA.

Continuity of Care
Members enrolled in the CMH, HD, PD, and AIDS/HIV HCBS waivers before October 1, 2026, will continue to receive HCBS services specified in their existing person-centered service plan, as available, under the two new waivers. From October 2026 to their next person-centered service plan, the CY and AD waivers will have a monthly cap on services by level of care. Participants and case managers will continue to have access to HHS's Waiver of Administrative Rules process to request needed supports and services that exceed the limitations allowed in the waiver.

Removed services
Service packages have been aligned with state plan services and EPSDT. As a result, In-home Family Therapy, Skilled and Unskilled Attendant Care, Nursing, Home Health Aide and Interim Medical Monitoring and Treatment (IMMT) are not offered on the CY waiver to avoid duplication. All these services except In-home Family Therapy are available on the AD waiver. Prior to October 1, 2026, for those enrolled in the CMH, HD, PD, and AIDS/HIV waivers, case managers will work with these members to ensure that they access these services through EPSDT and do not experience a disruption when the Children and Youth Waiver is implemented.

Adult Day Care is not offered on the CY waiver. Young adults ages eighteen to twenty who currently access Adult Day Care through the HD waivers will no longer be able to receive Adult Day Care services. Prior to October 1, 2026 for those on the HD waiver, case managers will work with these members to transition to other services (e.g. Medical Day Care for Children and Supported Employment).

Case management is not offered on the CY and AD waivers. Members enrolled in managed care will receive case management through their managed care organization. Fee-for-service members will access targeted case management through the state plan.

New services
Iowa HHS has added two new services to both the CY and AD waivers. Community Transition Services pay for important items and one-time services when adults move from a facility to their own home or when youth move to adult services. Peer Mentoring helps members adapt to and stay in their communities with the support, advice, and guidance of someone who has similar experiences. Members enrolled in these waivers will gain access to services that they did not have before, such as Prevocational and Supported Employment. It is the case managers responsibility to monitor the member throughout the transition to identify any unmet needs.

Level of care determination
Starting October 1, 2026, members on the two new waivers will be assessed using a uniform assessment, which is a complete assessment that looks at a person's unique strengths and needs and measures acuity to derive an individualized budget for members.

Individualized budgeting
Individualized budgeting will be used to align member needs with their service spending for the two new waivers. Members will be assigned to a monthly budget category based on their needs and will be able to make informed choices and decisions on what types of services and the amounts used within their monthly budget. A select number of services will be accessed as add-ons that are not subject to members' monthly budget limits.

The individualized budgeting approach is anticipated to launch July 1, 2027. Prior to this launch, beginning October 1, 2026, Iowa HHS will set budget caps based on level of care. This ensures that members can continue their current level of service utilization.

Starting with the second year of a member's transition, individualized budgets will be based on the combination of members' level of care determination and their level of need determined by the uniform assessment.

Provider engagement and qualifications
Iowa HHS is focused on making sure providers are ready to support those they serve by including providers in the development of the redesigned waivers providing access to trainings and resources.

Provider designation process. The State is developing a process to enable providers currentlyenrolled and certified to provide services under one of the current six 1915(c) waivers to becomeauthorizedto provide services under the new waivers for one year after the transition based on their current credentials. Lists of enrolled and certified providers will be provided to managed care organizations to ensure network development and adequacy.

Provider training to support the transition. The State will provide providers and managed care organizations with documentation clarifying training requirements for providers.

Billing during the transition. The State is creating a crosswalk of current 1915(c) billing codes and mapping those to services provided under the CY and AD waivers. Beginning on October 1, 2026, service providers for the CMH, HD, PD, and AIDS/HIV waivers will begin billing using the new billing guidance provided by the state. The past 1915(c) codes will be accepted for at least 6 months after October 1, 2027.

Development of materials, guidance, and infrastructure
The State will issue guidance materials that govern the populations and benefits impacted by this transition and will issue separate guidance targeted for specific audiences. The State will work with providers, MCOs, system navigators, member services call center staff, and other stakeholders to ensure a smooth transition.

Member communications
To ensure impacted members are notified and receive appropriate information relevant to the waiver transition, the State will engage in developing new and updating existing member communication strategy and materials. The member communication materials will use a variety of formats, such as access guides, quick guides, handouts, town halls, trainings, and listening sessions.

Information Technology (IT) Updates
The State will ensure systems for eligibility, enrollment, provider, cost reporting, encounter data, and claims payment support a seamless transition and continuity of care. These efforts are currently underway. The IT updates will support Medicaid managed care enrollment and ensured access to services, as well as provider enrollment and certification. Changes to claims and billing systems will support authorization of fee for service reimbursement, ensure defined allowable scope of benefits, and the ability to monitor expenditures.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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

QP-a2: Number and percent of licensed/certified waiver provider re-enrollments verified against the appropriate licensing/certification standards prior to continuing to furnish services.

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

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

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

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

   ◉ **The waiver is operated by the state Medicaid agency.**

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

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:

   Iowa Department of Health and Human Services, Iowa Medicaid, Long-Term Services and Supports (LTSS)

   (Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

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

Appendix A: Waiver Administration and Operation

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

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

This waiver operates concurrently with managed care.

-MCOs are responsible for managing covered benefits, including physical health, behavioral health and LTSS to the majority of waiver enrollees. Waiver operational and administrative functions that are performed on behalf of the Medicaid agency include:
- Identification of members who may be eligible for waiver services and referral for enrollment.
- Developing person-centered service plans, coordinating care, and authorizing and initiating waiver services for all members.
- Case management and monitoring receipt of services.
- Maintaining both a toll-free member and provider hotline for questions, concerns, or complaints.
- Operating a 24/7 toll-free Nurse Call Line which provides nurse triage telephone services for members to receive medical advice from trained medical professionals.
- Operating an incident reporting and management system.
- Maintaining a utilization management program.
- Conducting provider services such as network contracting, credentialing, enrollment and disenrollment, training, and claims processing.

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

- Member Services contractor disseminates information to Medicaid beneficiaries and provides support the members with required enrollment broker functions as part of the required Beneficiary Support Services.

- HCBS Quality Improvement Organization (QIO) contractor reviews HCBS providers for compliance with state and federal requirements, certifies HCBS providers to deliver specific HCBS, monitors complaints and critical incident reports, and provides technical assistance.

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

-HCBS Training and Technical Assistance contractor provides training and technical assistance to HCBS providers.

- Provider Services contractor conducts provider background checks, facilitates annual provider trainings, supervises the provider assistance call center, and manages the help functions associated with Iowa Medicaid’s Institutional and Waiver Authorization and Narrative System (IoWANS).

- Program Integrity contractor supports Fee-For-Service and MCOs integrity functions of the Medicaid agency.

-External Quality Review Organization (EQRO)- analyzes and evaluates aggregated information on quality, timeliness, and access to the health care services that a MCO or their contractors furnish to waiver enrollees.

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

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

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

-Point-of-Sale (POS) contractor is the pharmacy point of sale system. It is a real-time system for pharmacies to

submit prescription drug claims for Iowa Medicaid beneficiaries and receive a timely determination regarding payment.

Ultimately it is the Medicaid agency that has overall responsibility for all of the functions of the Medicaid and waiver program, though some functions are performed by contracted agencies.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

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

Iowa Medicaid is an endeavor that unites the state agency and competitively procured contractors into a performance-based model for the administration of the Iowa Medicaid program. Contract RFPs are issued every five years with the opportunity for additional one-year extension(s).

All contracted entities are assessed through their performance-based contracts and are required to be accountable for their performance related to scope of work and deliverables. Monthly meetings with contract managers and policy program managers are designed to facilitate communication among the various business units within Iowa Medicaid to ensure coordination of operations, reporting, and performance outcomes. Contracted agencies are required to complete a comprehensive quarterly report on their performance that include programmatic and quality measures designed to measure the contract activities as well as trends identified within Medicaid programs and populations.

The State has established a Managed Care and Oversight Bureau within Iowa Medicaid to provide comprehensive program oversight and compliance. Specifically, the Bureau Chief, reporting directly to the Medicaid Deputy Director, is responsible for directing the activities of bureau staff. HHS MCO account managers oversee contract compliance for their designated MCO. The MCO account managers serves as liaisons between the MCOs and the State and will be the point of contact coordinating communications and connecting subject matter experts. The Bureau also works directly with the Bureau of Program Integrity and Compliance Unit, which is the state staff team charged to oversee federal compliance with FFS and managed care, in addition to the Fraud, Waste and Abuse oversight.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's

methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
AA-1: Number and percent of required MCO HCBS PM quarterly reports that are submitted timely. Numerator = # of required MCO HCBS PM quarterly reports submitted timely; Denominator = # of MCO HCBS PM quarterly reports due in a calendar quarter.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Performance Monitoring

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Performance Monitoring

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Through the Bureau of Managed Care and Oversight each MCO is assigned a state contract manager the Medicaid Bureau of Contracting, who is responsible for oversight of contract compliance as well as a state data analyst to aggregate and analyze MCO data. These staff oversee the quality and timeliness of monthly reporting requirements. Whenever data is late or missing the issues are immediately addressed by each MCO contract manager of the respective MCO.

b. Methods for Remediation/Fixing Individual Problems

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

If the contract manager, or any HHS staff, discovers and documents a repeated deficiency in performance of the MCO, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of payment compensation. General methods for problem correction include additional oversight and revisions to state contract terms based on lessons learned.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance*

with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☒	**Disabled (Physical)**	0	20	
	☐	**Disabled (Other)**			
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☒	**Brain Injury**	0	20	☐
	☒	**HIV/AIDS**	0	20	☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☒	**Autism**	0	20	☐
	☒	**Developmental Disability**	0	20	☐
	☒	**Intellectual Disability**	0	20	☐
☒ **Mental Illness**					
	☐	**Mental Illness**			☐
	☒	**Serious Emotional Disturbance**	0	20	

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

Physical Disability: Individuals must be blind or disabled as determined by the receipt of social security disability benefits or through a disability determination made by the department. Disability determinations are made in accordance with supplemental security income guidelines under Title XVI of the Social Security Act or disability guidelines for the Medicaid employed people with disabilities coverage.

Brain Injury: Individuals with clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions.

HIV/AIDS: Individuals diagnosed by a physician as having AIDS or HIV infection.

Autism: Autism spectrum disorder (ASD) is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome.

Developmental Disability: Individuals diagnosed with a severe, chronic disability that: (1) Is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) Is manifested before the age of 22; (3) Is likely to continue indefinitely; (4) Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and (5) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. A person from birth to the age of nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described above if the person, without services and supports, has a high probability of meeting those criteria later in life.

Intellectual Disability: Individuals must have a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person's condition was during the developmental period and shall be based on an assessment of the person's intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills. The diagnosis shall be made in accordance with the criteria provided by in the DSM-V.

Serious Emotional Disturbance: Members must have a diagnosis of serious emotional disturbance (SED), defined as a diagnosable mental, behavioral, or emotional disorder that: (1) is of sufficient duration to meet diagnostic criteria for the disorder specified in the Diagnosis and Statistical Manual of Mental Disorders, fifth edition, (DSM-V) published by the American Psychiatrist Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a member's role or functioning in family, school, or community activities. SED shall not include developmental disorders, substance-related disorders, or conditions or problems classified in the DSM-V as other conditions that may be a focus of clinical attention" (V Codes), unless these conditions co-occur with another diagnosable serious emotional disturbance. Psychological documentation that substantiates a mental health diagnosis of SED as determined by a mental health professional must be current within the 12-month period before the application date.

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

○ **Not applicable. There is no maximum age limit**

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

Specify:

Waiver participants, upon reaching the age of 21, may transition into the Adults with Disabilities (AD) waiver if they meet eligibility criteria and wish to continue receiving HCBS waiver services. The waiver participant's case manager will discuss with individuals, at least six months prior to aging out of the Children and Youth waiver, of the option to apply for AD waiver services and provide any assistance requested. The AD waiver maintains reserved capacity slots for individuals transitioning from the Children and Youth waiver to maintain continuity of care and needed services. To support seamless transition, case managers will be required to support members who do not have a current disability determination to obtain one beginning at age 18 so that a person can transition to the AD without any delays.

Waiver participants who do not wish to transition to the AD waiver but will maintain full Medicaid also have the option to access other State Plan services and/or apply for Habilitation Services upon aging out of the Children and Youth waiver. Habilitation Services are State Plan services available to Medicaid members meeting the Habilitation Services eligibility criteria. Transition planning is done by the case manager for eligible members prior to the member turning 21.

Some waiver members may not qualify for the AD waiver or Habilitation Services or choose to not receive services. It is important to note that transition planning does occur for all Children and Youth members who will age out of the waiver, regardless of their intent to continue services. For fee-for-service members, the State uses IoWANS to remind the case manager when an enrolled member reaches age 20 and that transition planning should occur. MCOs are responsible for implementing processes to notify case managers of their enrolled members.

Appendix B: Participant Access and Eligibility

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

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

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

    [ ]

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

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver

participants. Complete Items B-2-b and B-2-c.

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

- ○ **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

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

    Specify the formula:

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

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

  Specify percent:

- ○ **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	3408
Year 2	3408
Year 3	3408
Year 4	3408
Year 5	3408

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

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	2188
Year 2	2188
Year 3	2188
Year 4	2188
Year 5	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
	2188

Appendix B: Participant Access and Eligibility

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

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

○ **Not applicable. The state does not reserve capacity.**

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

Purpose(s) the state reserves capacity for:

Purposes	
Children in Institutions	

Appendix B: Participant Access and Eligibility

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

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

Children in Institutions

Purpose *(describe):*

Slots are available for use by any eligible person for the Child and Youth waiver residing in in a state Mental Health Institute, a Nursing Facility, Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID), PMIC, Qualified Residential Treatment Provider, or in an out of state facility placement or inpatient hospital setting and has been residing there at least four months and is choosing this waiver program over institutional services to return to their family or foster family home. Slots will be allocated based on the date of application for the reserved slot.

Describe how the amount of reserved capacity was determined:

Waiver slots are based on anticipated movement of children from institutional placements into community and based on prior experience.

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

Waiver Year	Capacity Reserved
Year 1	100
Year 2	100
Year 3	100
Year 4	100
Year 5	100

Appendix B: Participant Access and Eligibility

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

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served

subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Per Iowa Administrative Code 441 Chapter 83, if no waiver slot is available, HHS enters applicants onto a waiver waiting list.

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

Applicants will receive numeric risk scores based on their responses to the risk of institutionalization, emergent needs, urgent need criteria, and population of interest questions. Scoring methodology is presented with the questions below. If applicants receive equal risk scores, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list.

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

For purposes of the WPNA, an "Adult" is anyone is 18 and older.

Risk of institutionalization criteria is as follows:

1. The individual has stayed overnight at a hospital in the last 3 months for a reason other than giving birth.
For Adults:
a. 1 inpatient stay- Score :3
b. 2 inpatient stays- Score: 5
c. 3-4 inpatient stays- Score: 7
d. 5+ inpatient stays- Score: 9

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

2. The individual has visited an emergency department (not urgent care) at least twice in the last 3 months.
For Adults:
2 or more visits- Score :2

For Children:
2 or more visits- Score :1

3. Has the individual been diagnosed with HIV/AIDS Yes- Score :1

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

Emergency need criteria are as follows (Check all that apply) Each Scores 2
1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.
2. The individual has lost or will be losing housing within 30 days and has no other housing options available.
3. The individual is living in a homeless shelter, and no alternative housing options are available.
4. There is founded abuse or neglect by a caregiver or others living within the home of the individual, and the individual must move from the home.
5. The individual cannot meet basic health and safety needs without immediate supports. (Not applicable to children under age 18 due to parental responsibility)
6. The individual is in danger or will experience abuse or neglect if the individual does not receive immediate support or

services
7. The individual is in crisis and admission to a facility will be expected without supports in the next 30-60 days.
8. The caregiver is in extreme stress or pressure and will not be able to provide for the individual's health and safety if supports are not provided in the next 30 to 60 days.

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

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

6. Population of Interest: If the individual been diagnosed with HIV/AIDS Yes- Score :1

Applicants who do not meet risk of institutionalization, have emergent need, urgent need criteria, or are in the population of interest shall remain on the waiting list based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list. Applicants shall remain on the waiting list until a waiver slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may complete and submit a WPNA for consideration at that time. The outcome of the assessment shall determine placement on the waiting list. To maintain the approved number of members in the program, persons shall be selected from the waiting list as waiver slots become available, based on their priority order on the waiting list. Once a waiver slot is assigned, the department shall give written notice to the person within five working days. The department shall hold the waiver slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **Section 1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

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

- ( ) **No**
- (●) **Yes**

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

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

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

☒ **SSI recipients**

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

☒ **Optional state supplement recipients**

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

Select one:

○ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

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

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

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

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

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

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

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

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

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

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

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

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

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

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

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

○ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state plan**

Specify:

○ **The following dollar amount**

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

○ **The following formula is used to determine the needs allowance:**

Specify:

◉ **Other**

Specify:

HHS determines patient liability. Client participation is the amount that a member is required to contribute toward the cost of waiver services. To calculate client participation: 1. Determine only the member's total gross monthly income. 2. Subtract a maintenance needs allowance of 300% of the current SSI benefit for one person. 3. For participants who have a medical assistance income trust (Miller Trust) subtract: a. an additional $10 for trustee fee b. A deduction for spouse and/or dependent needs 4. A deduction for any unmet medical expenses of the participant. 5.Add in veteran's aid and attendance, house-bound allowance, or other third-party payments not counted as income for eligibility. The result is the client participation amount.

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

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

○ **Not Applicable (see instructions)**

- (●) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

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

  Specify:

- ( ) **Other**

  Specify:

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

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

Select one:

- ( ) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- (●) **The state does not establish reasonable limits.**
- ( ) **The state establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:
- ◉ **Other**

  Specify:

  HHS determines patient liability. Client participation is the amount that a member is required to contribute toward the cost of waiver services. To calculate client participation: 1. Determine only the member’s total gross monthly income. 2. Subtract a maintenance needs allowance of 300% of the current SSI benefit for one person. 3. For participants who have a medical assistance income trust (Miller Trust) subtract: a. an additional $10 for trustee fee b. A deduction for spouse and/or dependent needs 4. A deduction for any unmet medical expenses of the participant. 5.Add in veteran’s aid and attendance, house-bound allowance, or other third-party payments not counted as income for eligibility. The result is the client participation amount.

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

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

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

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By an entity under contract with the Medicaid agency.**

Specify the entity:

Iowa Medicaid’s Core Standardized Assessment (CSA) contractor performs the Level of Care (LOC) assessments. The Iowa Medicaid QIO Medical Services Unit is responsible for making all initial and annual LOC decisions. LOC decisions also include input from the case manager, medical professional, and other appropriate professionals.

- ○ **Other**

Specify:

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

The initial evaluation/completion of the assessment tool must be completed by a medical professional (i.e., licensed physician, physician assistant or advanced registered nurse practitioner). Level of care determinations must be completed by a licensed RN, Physician Assistant, or MD.

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

All criteria outlined in this section apply to both initial and reevaluation of Level of Care. Iowa Medicaid QIO Medical Services uses the approved interRAI assessment tools to determine level of care for the Children and Youth Waiver.

Iowa's interRAI assessment suite includes:

Early Years (EY) for ages 0 - 3
Pediatric Home Care (PEDS-HC) for ages 4 – 20
Child and Youth Mental Health (ChYMH) for ages 4 – 15
ChYMH-Developmental Disabilities (ChYMH-DD) for ages 4 - 18
Intellectual Disability (ID) for ages 18+
*Home Care (HC) for ages 21+

*In some instances, interRAI Home Care will be used as youth are getting close to aging out of the waiver and will be transitioning to the AD waiver.

The interRAI assessment suite has been designed to be a user-friendly, reliable, person-centered assessment system that informs and guides comprehensive care and service planning in community-based settings around the world. It focuses on the member's functioning and quality of life by assessing needs, strengths, and preferences, and facilitates referrals when appropriate. When used over time, it provides the basis for an outcome-based assessment of the member's response to care or services. In addition to the interRAI assessment questions, supplemental questions may be added to ensure each member's needs are fully understood and captured in the assessment process.

There are five levels of care – ICF/ID, NF, SNF, Pediatric SNF and, PMIC (Hospital) as specified below.

ICF/ID

1.IAC 441-83.60(249A) requires the diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay or unspecified intellectual disability (intellectual developmental disorder) as outlined in the DSM-5, using a standardized full battery test of intellectual abilities.
a. Deficits in intellectual functions confirmed by both clinical assessment and individually administered and valid tests of intelligence.
b. Deficits in adaptive functioning in at least ONE of the following areas: Conceptual OR Social OR Practical requiring support to perform adequately in at least one life setting (school, work, home).
c. Deficits in adaptive behavior must be directly related to criterion a.
d. Onset of intellectual and adaptive deficits during the developmental period.

2.Member has a related condition as defined in 42 CFR Chapter IV part 435 section 1010. The condition must be severe, chronic, attributed to specific conditions like cerebral palsy or epilepsy, manifested before the age of 22, likely to continue indefinitely, and result in substantial functional limitations in three or more major life activity areas.

3.Member has deficits in at least THREE activities of daily living such as mobility, musculoskeletal skills, toileting, etc.

Members with related conditions (42 Code of Federal Regulation [CFR] 435.1010) without a DSM qualifying diagnosis of intellectual disability may qualify for ICF/ID facility services when they meet criteria 2 AND 3.

NF

NF LOC is considered medically necessary when ALL the following are met:

1.Presence of a physical or mental impairment which restricts the ability to perform the essential activities of daily living; bathing, dressing, and personal hygiene; and impedes the capacity to live independently. The member's physical or mental impairment is such that safe self-execution of the required nursing care is improbable or impossible; AND

2.Services are provided in accordance with general provisions for all Medicaid providers and services as described within Iowa Administrative Code (IAC) 441-79.9.

SNF

To approve SNF LOC for age 18 and older, ALL the following must be met:
1.The member’s medical condition requires SNF services or skilled rehabilitation services as provided in 42 CFR 409.31(a), 409.32, and 409.34. §409.31 Level of care requirement.

2.Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and are furnished directly by, or under the supervision of, such personnel.

3.The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF or an inpatient basis.

Pediatric SNF

These criteria apply to skilled nursing facility (SNF) members or Medicaid members who are residing in their homes with skilled care needs who are 17 years of age and younger. In order for the SNF level of care to be approved, ALL the following conditions must be met:

1.Member requires SNF services or skilled rehabilitation services; AND

2.Receives these skilled services on a daily basis:
a. Nursing services (registered nurses or licensed practical nurses) 7 days a week; AND/OR
b. Therapy services (physical therapist, occupational therapists, speech pathologists, audiologists), at least 5 days a week; AND
c. The daily skilled services cannot be provided at a lower level of care, such as an intermediate care facility; AND

3.Skilled services must be provided as a result of licensed practitioner’s orders and must be reasonable and necessary for the treatment of the member's illness or injury; AND

4.An individualized care plan that identifies support needs; AND

5.Confirmation that skilled services are provided to the member; AND

6.Member will have at least one deficit in at least one of the nine systems/categories identified below; AND

7. Member must require another individual to complete the service. Cares performed by the member independently are not skilled cares; skilled cares may be performed by nonskilled members with direct training from skilled members only when documentation of direct supervision, refresher training, and/or review of the skilled service every 6 months by licensed skilled professionals.

Skilled services must include at least ONE of the following (1 through 9):
1. Musculoskeletal
2. Skin
3. Respiratory Status
4. Elimination
5. Activities of Daily Living
6. Nutritional Status/Fluid Balance
7. Drug Therapy
8. Sensory--Motor
9. Teaching/Care Plan Management and Evaluation.

Psychiatric Medical Institution for Children (Hospital)

The member must meet ALL criteria in Sections 1, 2, and (a) and either (b) or (c) in Section 3 to meet the admission level of care.

1.Member diagnosed with a serious emotional disorder (SED) by a mental health professional within the 12-month period before the assessment date.

2.Level of stability - must meet ALL the following:
a. Member demonstrates a risk to self-and/or others but can be managed with services available through the Children and Youth waiver. The risk of harm meets the current standard of practice for imminent risk necessitating a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under 21 years of age; AND
b. Treatments at lower level of care (outpatient services such as mental health therapy, behavioral health intervention services, group therapy, family therapy, and/or medications) are in place, but additional supports are needed and recommended.

3.Degree of impairment because of an SED must meet Section (a) AND either (b) or (c):
a. Impairment in judgment, impulse control, and/or cognitive and/or perception that indicates the need for close monitoring, supervision, and intensive intervention beyond what can be addressed with typical outpatient treatment; AND

b. Social/Interpersonal/Familial: Significantly impaired interpersonal functioning that requires active intervention beyond typical outpatient treatment to resume an adequate level of functioning; OR
c. Educational/Prevocational/Vocational: Impairment in educational and/or prevocational/vocational functioning and may be identified by an individualized education plan team as having emotional/behavioral disability that requires active intervention beyond typical outpatient treatment.

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

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

The Iowa Medicaid QIO Medical Services Unit is responsible for determining LOC for members receiving services in institutional settings and the HCBS waiver. The review coordinators use the same functional criteria for both programs. The HCBS waiver uses items within the interRAI suite to determine level of care whereas level of care within an institutional setting is determined through pre-admission requirements to include certification of need by a licensed physician of medicine or osteopathy and approval by the Iowa Medicaid QIO Medical Services Unit. Because the same criteria are used for both institutional care and waiver services, the outcome is reliable, valid, and fully comparable.

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

IoWANS system starts workflow to initiate the assessment for an individual to determine their initial and annual level of care. The assessment is completed by the Core Standardized Assessment (CSA) contractor and is then sent to the Iowa Medicaid QIO MSU.

The Iowa Medicaid QIO MSU is responsible for determining the level of care based on the completed assessment and supporting documentation. The Continued Stay Review (CSR) is completed annually and when the case manager becomes aware that the member's functional or medical status has changed in a way that may affect functional eligibility. The CSR process uses the same assessment tool as is used with the initial level of care determination. IoWANS system sends out a milestone notification 60 days prior to the CSR date to remind case managers of the upcoming annual LOC. The CSA contractor completes these assessments. A case manager or member can request a reevaluation at any time. The State retains authority for determining Medicaid categorical, financial, LOC or needs-based eligibility and enrolling members into a Medicaid eligibility category.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

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

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

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

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

One hundred percent (100%) of member LOC reevaluations must be completed within twelve (12) months of the previous evaluation. On a weekly basis, an IoWANS CSR report is extracted to identify overdue reevaluations and sent to the CSA management team for resolution. The CSA management team submits a weekly status report to the designated HCBS program manager for monitoring with conferencing as needed.

A CSR or re-evaluation report is also available through IoWANS to track overdue reevaluations and is monitored by Iowa Medicaid.

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

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

All evaluation and reevaluation level of care documents are submitted to the QIO regardless of delivery system (i.e., FFS members and MCO members) and placed in OnBase, the system that stores documents electronically and establishes workflow. The waiver member’s case manager is responsible for maintaining a working case file for each member and must maintain the records for a period of five years from the date of service. The case file includes all assessments, both initial and ongoing, completed during the time the member was receiving waiver services. MCOs also maintain electronic case management systems that are used to capture and track all member assessments and person-centered service plans.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
LC-c1: Number and percent of initial level of care decisions that were accurately

determined by applying the approved LOC criterion using standard operating procedures. Numerator: # of initial LOC decisions that were accurately determined by applying the approved LOC criterion using standard operating procedures; Denominator: # of reviewed initial LOC determinations

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted Entity	☐ **Annually**	☒ **Stratified** Describe Group: IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data for completed LOC is collected quarterly through reports generated through IoWANS, MQUIDS, and OnBase. This data is monitored for trends from an individual and systems perspective to determine in procedural standards. Monthly a random sample of LOC decisions is selected from each reviewer. Internal quality control activity is completed on the random sample. This level of scrutiny aids in early detection of variance from the stated LOC criteria.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

The state's QIO Medical Services Unit performs internal quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred, the unit undertakes additional training for staff. When an eligibility approval is made in error, the State allows for timely notice and discontinues the participant's benefits. All payments that were made for services, in which the participant was not actually eligible for, are deemed as an error and an overpayment is set to be collected from the participant. The eligibility worker reaches out to the participant at that time, explains to them what happened and encourages them to not use any additional services that will need to be repaid. If the participant is only eligible due to being eligible for the waiver, all Medicaid and

waiver payments will be subject to the overpayment. If the participant is eligible for Medicaid on their own right, then only the waiver services are subject to the overpayment recoupment.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Contracted Entity	☐ **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 Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

In accordance with 42 CFR 441.301 and the Iowa Administrative Code 441-90 and 441-83, service plans must reflect the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan, developed through a "person-centered" planning process, must reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports.

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

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

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

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

In addition, HCBS QIO reviews the service plan to determine if provider choice (including CCO) is offered.

HCBS QIO conducts monthly ride-along activities for all service plan coordination and evaluates compliance with service planning requirements, including choice between institutional and HCBS services. Feedback is provided to LTSS Policy for oversight as well as the MCO account managers, FFS Case Managers/Supervisors, and MFP Transition Specialist who then follow up on any necessary corrective actions.

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

Freedom of Choice for fee-for-service members is documented in member person-centered service plans and Freedom of Choice forms are maintained in IoWANS.

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- MCOs must conform to HHS policies regarding meaningful access to the waiver by limited English proficient persons, and to deliver culturally competent services in accordance with 42 CFR 438.206.
- MCOs must provide language services at no cost to limited English proficiency members, and all written materials shall be provided in English and Spanish, as well as any additional prevalent languages identified by the State or through an analysis of member enrollment (i.e., any language spoken by at least five percent (5%) of the general population in the MCO’s service area).

- MCOs must provide oral interpretation services free of charge to each member (this applies to all non-English languages, and is not limited to prevalent languages), and MCOs must notify all members that oral interpretation and translated written information is available and how to access those services. Written materials must include taglines in prevalent languages regarding how to access materials in alternative languages.
- MCOs must ensure that service plans reflect cultural considerations of the member and that service plan development is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b).
- MCOs must operate member services helplines that are available to all callers, and an automated telephone menu options must be made available in English and Spanish.
- MCOs must maintain member websites and mobile applications available in English and Spanish that are accessible and functional via cell phone.

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

Appendix C: Participant Services

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

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	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:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Prevocational Services 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:

12 Services Supporting Self-Direction

Sub-Category 1:

12010 financial management services in support of self-dir

Category 2:

Sub-Category 2:

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

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

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

Provider Category	Provider Type Title
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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Case Managers develop person centered service plans (PCSPs) for members receiving HCBS waiver services. All Case Managers are required to meet all of the qualifications, requirements, and be accredited as specified in 441 Iowa Administrative Code Chapter 24 and Chapter 90.

Case managers serving LTSS populations that are hired complete the Agency-identified initial training curriculum on the Agency'sLearning Management System (LMS) platform within six (6) months of hire. Case managers serving LTSS populations must also complete the Agency-identified refresher curriculum on an annual basis within 365 calendar days since the most recent completion date of the initial or refresher curriculum.

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

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

2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.

People employed as case management supervisors on or before August 1, 1993, who do not meet these requirements shall be considered to meet these requirements as long as they are continuously employed by the same case management provider.

In addition, Targeted Case Managers (TCM) may be required to have the following specified experience in the following areas if they are specifically working with these populations:
- Developmental disabilities: a minimum of one-year full-time (or equivalent part-time) experience in delivering or coordinating services for persons with developmental disabilities (i.e., severe, chronic mental or physical impairments). Positions that meet the intellectual disability background noted above will normally meet this selective area too. Experience in providing services and treatment to autistic children or persons with epilepsy or cerebral palsy will also qualify.
- Intellectual disability: a minimum of one year of full-time (or equivalent part-time) experience in delivering or coordinating services for persons with significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior manifested during the developmental period.

Case Managers serving Enrolled Members that have chosen self-direction through the Consumer Choices Option shall have specific experience with self-direction and additional training regarding self-direction.

Iowa Medicaid reserves the right to establish MCO Community-Based Case Manager to Enrolled Member ratios. Iowa Medicaid reserves the right to require the MCOs to hire additional community-based case managers if it is determined, at the sole discretion of Iowa Medicaid, that the MCO has insufficient CBCM staff to perform its obligations under the Contract

The MCOs are responsible for ensuring that training is also provided on designated topics within the Agency-identified curriculum that are not provided by the Agency.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Information related to waiver services and general waiver descriptions are initially made available following receipt of a waiver application. Informational materials are also available at each of the HHS county offices as well as on the Iowa Medicaid and MCO websites. Iowa Medicaid Member Services Unit remains available during normal business hours to answer questions and offer support to all Medicaid members. Additionally, quarterly member education is provided in an effort to continually educate waiver members about services and supports that are available but may not have been identified during the person centered service plan development process.

During person centered service plan development, the member and/or their representative is strongly encouraged to engage in an informed choice of services. The member determines who is part of the service planning team, often including their representative, case manager, service providers, and other supporting persons. These are individuals with adequate knowledge, training and expertise in community living and person-centered service delivery. The member also chooses who serves as the lead and the main point of contact. If the member chooses to self-direct services, there is the option of an Independent Support Broker to assist with budgeting and employer functions.

The FFS and MCO person-centered planning processes also must:
- Promote self-determination principles and actively engage the member;
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Provide information in plain language and in a manner that is accessible to individuals with disabilities and limited English proficiency, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning members;
- Include a method for the member to request updates to the plan as needed
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenient to the member;
- Reflect cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning members;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and
- Record the alternative home and community-based settings that were considered by the member.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Person centered service plans for FFS and MCO waiver participants are developed by the member, case manager, and an interdisciplinary team. Planning meetings are scheduled at times and locations convenient for the individual. The person-centered service plan must be completed prior to waiver services being delivered and annually thereafter, or whenever there is a significant change in the member's situation or condition.

An independent assessment entity completes the uniform assessment, comprised of interRAI assessment instruments and supplements, is used to collect information to support person-centered service planning. InterRAI assessment instruments review a wide range of areas, including but not limited to, community and social involvement, strengths, relationships and supports, independence in everyday activities and cognition and executive functioning. These instruments are coded using observations across specific timeframes and include multiple scales and algorithms to capture risk levels across areas of need to derive measures of functional status. Collaborative Action Plans (CAPs), evidence informed treatment guidelines, are used to help the interdisciplinary team to identify areas of need and prioritize services. Services may not be reduced, modified or terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. Changes to these must receive HHS prior approval.

The service planning team lead and case manager use information gathered from the uniform assessment and then works with the member to identify individual and family strengths, needs, capacities, preferences and desired outcomes, health status and risk factors. This guides the scope of waiver and state plan services included within the member's person-centered service plan. A summary of the assessment becomes part of the person-centered service plan.

Case managers are responsible for informing members of all available non-Medicaid and Medicaid services, including waiver services, and reviewing state plan services to avoid service duplication.

The case manager will also discuss with the member the self-direction option and give the member the option of self-directing services available. The member and the interdisciplinary team choose services and supports that meet the member's needs and preferences, as well as availability and appropriateness of services, which become part of the person-centered service plan. In accordance with 42 CFR 441.301 and 441 Iowa Administrative Code Chapters 90 and 83, MCOs must ensure the person centered service plan reflects the services and supports that are important for the member to meet the needs identified through the needs assessment, and are important to the member preferences for the delivery of services and supports, and how those needs will be met by community supports.

Planning meetings are scheduled at times and locations convenient for the individual. The team is also responsible for identifying an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or when the member's needs change. Service plans are completed prior to services being delivered, reevaluated annually, and whenever there is a significant change in the member's situation or condition, or at a member's request.

For both fee-for-service and MCO members, person centered service plans must use a standard template to:
- Reflect that the setting in which the individual resides is chosen by the member;
- Reflect the member's strengths and preferences;
- Reflect the clinical and support needs as identified through the needs assessment;
- Include individually identified goals and desired outcomes which are observable and measurable;
- Include the interventions and supports needed to meet member's goals and incremental action steps as appropriate;
- Reflect the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
- Include the identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the person centered service plan;
- Include a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights (for this purpose, rights include maintenance of personal funds and self-administration of medications);
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Include a plan for emergencies;
- Be understandable to the member receiving services and supports, and the individuals important in supporting him or her;
- Identify the individual and/or entity responsible for monitoring the plan;

- Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the member and other people involved in the plan;
- Indicate if the member has elected to self-direct services and, as applicable, which services the member elects to self-direct; and
- Prevent the provision of unnecessary or inappropriate services and supports.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the evaluation/reevaluation of level of care, risks are assessed by an independent assessor using the assessment tools designated in B-6e. The assessment becomes part of the person-centered service plan, and any risks are addressed by the case manager as part of the person-centered service plan development process. The comprehensive person-centered service plan must identify an emergency backup support and crisis response plan to address problems or issues arising when support services are interrupted or delayed or the member's needs change. In addition, providers of applicable services shall provide for emergency backup staff. All person-centered service plans must include a plan for emergencies and identification of the supports available to the member in an emergency.

Case Managers work with the member and their providers to develop a backup plan which will provide for the delivery of services to the member in the event that the service provider responsible for providing services does not show up or is otherwise unable to provide the scheduled services. Backup may include accessing the provider's on-call system, contacting family or other natural supports.

Emergencies are those situations for which no approved individual program plan exists and which, if not addressed, may result in injury or harm to the member or other persons or significant amounts of property damage.

Emergency plans are developed on the following basis:
- Providers must provide for emergency, back-up staff in applicable services.
- Interdisciplinary teams must identify emergency plans in the person-centered service plan, as appropriate for the individual member health and safety issues based on information gathered prior to the team meeting, including a risk assessment.

Personal Emergency Response is available under the waiver, and it is encouraged that this service be used as part of emergency backup plan when a scheduled support worker does not appear. Other providers may be listed on the person-centered service plan as source of back up as well. All members choosing the self-direction option will sign an individual risk agreement that permits the member to acknowledge and accept certain responsibilities for addressing risks.

Iowa Medicaid has developed a computer program named Institutional and Waiver Authorization and Narrative System (IoWANS) to support HCBS programs. For fee-for-service members, this system assists the Medicaid Agency and the case manager with tracking information, monitoring, and approving the person-centered service plan. Through IoWANS the case manager authorizes service and service payments on behalf of the member. There are certain points in IoWANS process that require contacting the designated HHS central office personnel. The case manager is responsible for the development of the person-centered service plan and the person-centered service plan is authorized through IoWANS, which is the Medicaid Agency. (Refer to appendix A and H for IoWANS system processes.)

MCOs have processes to ensure the necessary risk assessments and mitigation plans are completed and made available to all parties.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Information about qualified and accessible providers is available to members on an ongoing basis through the Iowa COMPASS services and resource database, Iowa Medicaid website, MCO websites, and MCO and Iowa Medicaid member services. The case manager first identifies providers to the member and their interdisciplinary team during the person-centered service planning process. Members are encouraged to meet with the available providers before making a selection. Members are not restricted to choosing providers within their community. If an MCO is unable to provide services to a particular member using in-network providers, the MCO is required to adequately and timely cover these services for that member using out-of-network providers, for as long as the MCO's provider network is unable to provide them. The MCOs are responsible for authorizing services for out-of-network care when they do not have an in-network provider available within the contractually required time, distance, and appointment availability standards.

The MCO is responsible for assisting the member in locating an out-of-network provider, authorizing the service and assisting the member in accessing the service. The MCO will also assist with assuring continuity of care when an in-network provider becomes available. To ensure robust provider networks for members to choose from, MCOs are not permitted to close provider networks until adequacy is fully demonstrated to, and approved by, the State. Further, members will be permitted to change MCOs to the extent their provider does not ultimately contract with their desired MCO. Finally, MCOs are required to submit to the State on a regular basis provider network reports including, but not limited to network geo-access reports, 24- hour availability audit reports, provider-credentialing reports, subcontractor compliance summary reports, and provider helpline performance reports.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

HHS has developed a computer system named the Institutional and Waiver Authorization and Narrative System (IoWANS) to support HCBS programs. This system assists HHS with tracking information, monitoring, and approving service plans for fee-for-service members. (Refer to appendix A and H for IoWANS system processes.) On a monthly basis, Iowa Medicaid QIO MSU conducts service plan reviews to ensure a practice of person-centered service planning in accordance with §441.301(c). The service plan selection size for the waiver has a 95% confidence level. This information is reported to CMS as part of Iowa's performance measures. The State retains oversight of the MCO service plan process through a variety of monitoring and oversight strategies as described in Appendix D – Quality Improvement: Service Plan section. IoWANS will only be utilized for fee-for-service members and quality data for managed care participants will be provided by the MCOs.

All members will receive a person-centered service plan using an HHS approved template.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

☒ **Medicaid agency**

☐ **Operating agency**

☒ **Case manager**

☒ **Other**

Specify:

Case managers are responsible for ensuring that copies of the person-centered service plans (PCSP) are maintained for a minimum of 5 years.

MCO and FFS PCSP are developed using a standardized form and the final signed PCSP is stored in a central location, the Iowa Medicaid Provider Access Portal (IMPA), managed by Iowa Medicaid. Case managers are required to upload member's PCSP plans to IMPA as well as store them within their organization’s own case management systems. PCSPs must be made available to all entities acting on behalf of Medicaid.

For FFS members, IoWANS also stores the authorized PCSP information related to service, provider, units, rates, and timeframe of authorization.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers and ultimately HHS are responsible for monitoring the implementation of the person-centered service plan and the health and welfare of fee-for-service members, including:

-When participants first become eligible for the waiver, and when they first enroll with the MCO, at least one face to face contact per month for the first three (3) months.
- After the first (3) months: 1. At least one, in-home, face-to-face contact every other month with Enrolled Members who have a diagnosis of intellectual and/or developmental disability and every three (3) months for all other community-based LTSS members. 2. At least one contact per month with the member or the member's authorized representative. This contact may be face-to-face or by telephone. Written communication does not constitute a contact unless there are extenuating circumstances outlined in the Enrolled Member's person-centered service plan.
- Monitoring service utilization.
- Participating in the development and approval of the service plan in coordination with the interdisciplinary team at least annually or as needs change. If services have not been meeting member needs, the plan is changed to meet those needs. The effectiveness of the emergency backup plan is also addressed as the service plan is developed.

The member is encouraged during the time of the service plan development to call the case manager if there are any problems with either Medicaid or non-Medicaid services. The case manager will then follow up to solve any problems. Monitoring service utilization includes verifying that:
- The member used the waiver service at least once a calendar quarter.
- The services were provided in accordance with the plan.
- The member is receiving the level of service needed.

IoWANS is also used to assist with tracking information, monitoring services, and assuring services were provided to fee-for-service members. If the member is not receiving services according to the plan or not receiving the services needed, the member and other interdisciplinary team members and providers are contacted immediately.

The HCBS specialists (of the HCBS QIO Unit) monitor how member health and welfare is safeguarded, the degree of person-centered service plan implementation; and the degree of interdisciplinary team involvement of the case manager during the HCBS QIO review. Members are asked about their choice of provider, whether or not the services are meeting their needs, whether staff and care coordinators are respecting their choice and dignity, if they are satisfied with services and providers, or whether they feel safe where they receive services and live.

HCBS specialists also review the effectiveness of emergency back-up and crisis plans and offer recommendations for improvements based on the findings. These components are monitored through quality oversight reviews of providers, member satisfaction surveys, complaint investigation, and critical incident report follow-up. All providers are reviewed at least once over a five-year cycle and members are surveyed at a 95% confidence level.

The Iowa Medicaid MSU also conducts quality assurance reviews of member person centered service plans at a 95% confidence level and provides recommendations for improvements based on the findings. These reviews focus on the plan development, implementation, monitoring, and documentation that is completed by the case manager. All service plans reviewed are assessed for member participation, whether the member's needs are accurately identified and addressed, the effectiveness of risk assessments and crisis plans, member access to waiver and non-waiver services, as well as coordination across providers to best serve the member's needs.

MCOs are responsible for monitoring the implementation of the person-centered service plan, including access to waiver and non-waiver services, the quality-of-service delivery, and the health, safety and welfare of members and choice of service providers. After the initiation of services identified in a member's service plan, MCOs monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the person-centered service plan.

MCO case managers identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively. If problems are identified, MCOs complete a self-assessment to determine what additional supports, if any, could be made available to assist the member. MCOs must develop methods for prompt follow-up and remediation of identified problems; policies and procedures regarding required timeframes for follow-up and remediation must be submitted to HHS for review and approval. Finally, any changes to a member's risk are identified through an update to the member's risk agreement. MCOs must report on monitoring results to the State.

In the event of non-compliance with service plan timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues.

If the MCO fails to develop a person-centered service plan for HCBS waiver enrollees within the timeframe mutually agreed upon between the MCO and HHS in accordance with the negotiated contract, the MCO will be assessed a noncompliance fee per occurrence.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
SP-a1: Number and percent of service plans that accurately address all the member's assessed needs, including at a minimum, health and safety risk factors, and personal goals Numerator = # of service plans that accurately address all the member's

assessed needs, including at a minimum, health and safety risk factors, and personal goals Denominator = # of reviewed person centered service plans

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☒ **Stratified** Describe Group: IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

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

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

Performance Measure:
SP-c1: Number and percent of CAHPS respondents who responded "YES" on the CAHPS survey to question 53 "In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?". Please see Main: Optional for the full description, including the Numerator and Denominator

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
FFS CAHPS and MCO CAHPS databases

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☒ **Stratified** Describe Group:

		IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP-c2: Number and percent of service plans which are updated on or before the member's annual due date. Numerator: # of service plans which were updated on or before the member's annual due date; Denominator: # service plans due for annual update that were reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted Entities including MCO	☐ **Annually**	☒ **Stratified** Describe Group: IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **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:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
SP-d1: Number and percent of members whose services were delivered according to

the service plan, including type, scope, amount, duration, and frequency specified in the plan. Numerator: # of members whose services were delivered according to the service plan, including type, scope, amount, duration, and frequency specified in the plan. Denominator: # of member's service plans reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☒ **Stratified** Describe Group: IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **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:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
SP-e1: Number and percent of CAHPS respondents who responded with either "MOST" or "ALL" on the CAHPS survey to question 56 "In the last 3 months, did your service plan include . . . of the things that are important to you". For Full description see Main B Optional

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
FFS CAHPS and MCO CAHPS databases

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted entity including MCO	☐ **Annually**	☒ **Stratified** Describe Group: IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP-e2: Number and percent of service plans from the HCBS QA survey review that indicated the member had a choice of HCBS service providers Numerator: Number of service plans from the HCBS QA survey review that indicated the member had a choice of HCBS service providers.; Denominator: Total number of service plans from the HCBS QA survey that were reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative**

		Sample Confidence Interval = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted entity including MCO	☐ **Annually**	☒ **Stratified** Describe Group: IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Data and results obtained by the HCBS QIO are reviewed by the Quality Assurance Committee at least annually. Results from the CAHPS and service plan Ride Along process are reviewed for issues and trends that may require corrective actions plans development. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

The HCBS QIO utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. MCOs are responsible for oversite of service plans for their members.

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Iowa offers self-direction services for members regardless of delivery system (FFS members or MCO members) through the Consumer Choices Option (CCO). The CCO offers both employer and budget authority to the member self-directing services. At the time of person-centered service plan development and/or at the member's request, the member has the option to convert certain applicable services into an individualized self-direction budget based on services that are authorized in their service plan. This individual monthly budget can be used to directly hire employees or purchase goods and services. A member may use individual-directed goods and services to meet their assessed needs. Individual-directed goods and services are services, equipment or supplies not otherwise provided through the Medicaid State Plan that address an identified need in the service plan. The item or services would decrease the need for other Medicaid services, and/or promote inclusion in the community, and/or increase the member's safety in the community or home.

Two budgets will be developed through service plan development: traditional services budget (includes services for which the member does not have budget or employer authority) and a self-direction individual budget (includes services and supports for which the member does have budget and employer authority). Members have authority over the individual authorized budget to perform the following tasks: (1) contract with entities to provide services and support; (2) determine the amount to be paid for services, excluding independent support broker and the financial management services, and consistent with 441 Iowa Administrative Code Chapter 79; (3) schedule the provision for services; (4) authorize payment for waiver goods and services identified in the individual budget; and (5) reallocate funds among services included in the budget. Individual monthly budget development includes the costs of the Financial Management Service (FMS), Independent Support Broker (ISB) if applicable, and any services and supports chosen by the member as optional service components.

If self-direction is elected, a FMS must be involved per state administrative rule. The FMS is a Medicaid provider and receives an electronic funds transfer (EFT) on a monthly basis for the member's monthly budget amount. The FMS is responsible for paying all employer taxes as required. Employees of the member are required to submit timecards within thirty days of providing the service for payment. As defined in Iowa Administrative Code 441 Chapter 78 the FMS performs services such as receiving Medicaid funds in an electronic transfer, process and pay invoices for approved goods and services included in the individual budget, provide real-time individual budget account balances during normal business hours, conduct criminal background checks on potential employees pursuant to 441—Chapter 119, verify citizenship status, assist the member with fiscal and payroll-related responsibilities, and assist the member with the completion of tax and insurance forms.

Members and their guardians will have the option to work with an ISB who will help them plan with their individual budget and services. The ISB works at the direction of the member and assists the member with their budget. For example, the ISB may help develop a monthly budget, recruit and interview potential employees, or assist with required paperwork. The ISB is required to attend an ISB training prior working with members. The ISB cannot be the guardian, power of attorney, or a provider of service to the member to avoid potential conflicts of interest. As defined in Iowa Administrative Code 441 Chapter 78 as directed by the member or the member's representative the ISB shall have contact with members at prescribed intervals, assist with interviewing potential employees and entities to provide services and supports, assist with contracts and payment methods, and review expenditure reports to ensure services are being provided.

The member may choose to set aside a certain amount of the budget each month to save towards purchasing additional goods or services they cannot buy from the normal monthly budget. A savings plan must be developed by the member and approved by HHS prior to implementation. The good or service being saved for must meet an assessed need identified in the member's service plan.

A utilization adjustment factor (UAF) is used to adjust the CCO budget to reflect statewide average cost and usage of waiver services. Annually, the department determines the average cost for each waiver service. The average service cost is used to determine the "cap amount" of the CCO budget. The cap amount is used to ensure the member stays within the program dollar cap limits within each waiver. The department also determines the percentage of services that are used, compared to what is authorized within a waiver service plan. This percentage is applied to the cap amount to determine the CCO "budget amount". The budget amount is the total funds available to the member in the monthly CCO budget. This UAF includes all HCBS waiver members in the calculation, not just members participating in CCO.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☒ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Self-direction training and outreach materials are available through the Iowa Medicaid website and MCOs. Materials include information on the benefits, responsibilities, and liabilities of self-direction. A brochure about this option has been developed and includes information about the benefits, responsibilities, and liabilities. MCOs must also provide ongoing member or representative training upon request and/or if it is determined a member needs additional training. Training programs are subject to approval by the department and designed to address the following: (i) understanding the role of members and/or representatives in self-direction; (ii) selecting and terminating providers; (iii) being an employer and managing employees; (iv) conducting administrative tasks such as staff evaluations and approval of time sheets; (v) scheduling providers; and (vi) back-up planning.

Case managers are required to discuss this option along with the benefits, responsibilities, and liabilities at the time of the person-centered service plan development and/or any time the member's needs change. This results in information about member direction activities being reviewed, at least annually, with the member. This option is intended to be very flexible; members can choose this option at any time. Once given information about this option, the member can immediately elect this option or can elect to continue or start with traditional services initially and then change to self-direction at a later date. All members must sign an informed consent contract and a risk agreement that permits the member to acknowledge and accept certain responsibilities for addressing risks.

To give the member an opportunity to locate providers and supports, the person-centered service plan can reflect that traditional services will begin at the start date of the service plan and the self-directed services and supports will begin at a later date. This does not require a change in the service plan. Members can elect self-direction and then elect to go back to traditional services at any time. The case manager is responsible for informing the member of their rights and responsibilities. All self-directed services and supports must begin on the first of a month.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Services may be self-directed by a non-legal representative freely chosen by a member. The policies described in this section apply to both the fee-for-service and managed care delivery systems. If the member selects a non-legal representative, the representative cannot be a paid provider of services and must be eighteen years or age or older. The member and the representative must sign a consent form designating who they have chosen as their representative and what responsibilities the representative will have. The choice must be documented in the member's file and provided to the member and their representative. At a minimum, the representative's responsibilities include ensuring decisions made do not jeopardize the health and welfare of the member and ensuring decisions made do not financially exploit the member.

Iowa Medicaid uses a quality assurance (QA) process to interview members in order to determine whether or not the representative has been working in their best interest. The interviews are completed primarily by telephone and may be completed in-person if requested. The interviews are conducted as an ongoing QA activity and are used to ensure that members' needs are met and that services are provided. QA interviews are completed monthly with a randomly selected representative sample of members.

In addition, the optional Independent Support Broker provides monitoring of health and safety. The member's case manager is responsible to monitor service delivery to assure that the member's health and safety are being addressed. Case managers review how services are being provided and monitor services to assure the member's needs are being met, including how the representative is performing.

MCOs are contractually required to maintain quality assurance processes to ensure that the representative functions in the best interest of the member. These quality assurance processes are subject to HHS review and approval and include, but are not limited to, monthly member interviews, to assess whether a non-legal representative is working in the best interest of the member. HHS provides additional oversight in accordance with the HCBS quality improvement strategy.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Individual Directed Goods and Services	☒	☒
Respite	☒	☒
Transportation	☒	☒
Prevocational Services	☒	☒
Supported Employment	☒	☒
Independent Support Broker	☒	☒
Home-Delivered Meals	☒	☒
Home and Vehicle Modifications	☒	☒
Assistive Devices	☒	☒
Medical Day Care for Children	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial

transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Service

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

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

MCOs are responsible for contracting with an FMS entity or entities to assist members who elect to self-direct. All MCO contracted FMS entities must meet the requirements documented in this section. Under the managed care delivery system, the FMS entity contracted with the MCO is responsible for the same functions as under the fee-for-service model.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS entities are paid a monthly fee for their services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Iowa Medicaid provides oversight of the FMS entities and monitors their performance at minimum annually, and more frequently as necessary. Financial integrity and program operational oversight may be conducted through a desk review, self-assessment or on-site as determined appropriate by HHS or agency representative. As noted above, FMS entities must also be enrolled as Medicaid providers. The MCOs are required to have similar oversight processes for their FMS entities related to compliance and monitoring outcomes.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional

information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The case manager provides the waiver member with information and assistance with choosing the CCO program as part of the person-centered service planning process. The case manager also assists the member in locating an optional Individual Support Broker to assist with planning and managing a monthly CCO budget. The case manager is responsible for monitoring the delivery of goods and services as identified in the service plan.

Members create support plans, make provider and service choices, select and employ staff, and monitor the quality of support services. MCOs are responsible for assisting the member with quality assurance activities and monitoring the quality of services provided. MCO plans to accomplish this contractual requirement are subject to HHS review and approval.

The CCO program conducts regular CCO webinars to provide case managers and ISBs with information on understanding and implementing the CCO program. The webinars also review self-direction issues that have been identified through quality assurance activities. All case managers are welcome to attend the webinars, which are also recorded and made available for those unable to attend.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Individual Directed Goods and Services	☐
Personal Emergency Response System or Portable Locator System	☐
Community Transition Services	☐
Respite	☐
Peer Mentoring	☐
Transportation	☐
Prevocational Services	☐
Supported Employment	☐
Positive Behavioral Support and Consultation	☐
Independent Support Broker	☒
Family and Community Support	☐
Home-Delivered Meals	☐
Home and Vehicle Modifications	☐
Assistive Devices	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Financial Management Services	☒
Medical Day Care for Children	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Through a contract with Iowa Medicaid the HCBS QIO provides support and assistance to case manager, members, providers, ISBs, and others needing information about HCBS waiver programs. This includes the self-direction program. Assistance provided includes developing and conducting regularly scheduled webinar trainings, developing and implementing required ISB training and answering questions about the CCO program.

The Quality Assurance and Technical Assistance contract is procured through a competitive bidding process. A request for proposal is issued every three years to solicit bids. The RFP specifies the scope of work to be completed by the contractor. The RFP process also includes a pricing component to assure that the contractor is reimbursed in an amount that assures performance outcomes are achieved in a cost-effective manner.

The Quality Assurance and Technical Assistance contract is managed by an Iowa Medicaid state employee. This employee acts as the contract manager and manages the day-to-day operations of the contract to assure compliance with the performance outcomes of the contract. Contract reports are received by Iowa Medicaid monthly, quarterly and annually on the performance measures of the contract. Any performance issues that arise are addressed with the Quality Assurance contract manager to make corrections and improve performance.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Members may receive traditional waiver services, as well as services and supports under an individual budget for self-direction. Any waiver member may voluntarily discontinue the self-direction option at any time, regardless of delivery system (FFS member or MCO members). The member will continue to be eligible for services as specified in the service plan, regardless of whether they select the self-direction option. A new person-centered service plan will be developed if the member's needs change or if they voluntarily discontinue the self-direction option. The case manager will work with the member to ensure that services are in place and that service continuity is maintained.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Self-direction option will be terminated at any time there is substantial evidence of Medicaid fraud or obvious misuse of funds. Involuntary termination can also occur if types of services provided, and the outcome of those services are unable to be verified. If the member and their representative are both found unable to self-direct, the member will be transitioned to traditional waiver services. The member has the right to appeal any adverse action taken to terminate self-directed services and is subject to the grievance and appeals protections outlined in Appendix F. The case manager will amend the person-centered service plan and assure alternative services are in place to maintain service.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		300
Year 2		315
Year 3		330
Year 4		345
Year 5		360

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Pursuant to Iowa Code 249A.29 and Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), all providers of HCBS waiver services must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a member. The State pays for the first background check of workers who provide waiver services to fee-for-service members. If a second background check is completed, it is the responsibility of the employee to pay for the background check. MCOs are responsible for the costs of investigations of workers who provide waiver services to members.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Same as C-2-a above.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☒ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☒ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Under the self-direction option, a member is not limited to the providers who have enrolled with Iowa Medicaid. The member is considered the employer and can choose any individual that they feel is qualified to provide the needed service. Members determine the wages to be paid to the provider and the units of service (limited by the self-direction budget). Interviewing, hiring, scheduling, and firing is done by the member. Claims are submitted to the FMS for processing for payment.

Each member who chooses to self-direct their services will continue to have a traditional person-centered service plan developed that is based on the level of care assessment and need of the member. If a member has a need for the services that can be included in the individual budget and they choose to self-direct one or all of those services, then the individual budget amount is determined by the amount of services that were authorized under the traditional service plan. The level of need is determined by the level of care determination made by Iowa Medicaid MSU; the type and amount of supports needed determined by a review of the assessment conducted prior to the member selecting the self-direction option. Members who reside in an assisted living facility may also choose to self-direct some of their services. Specifically, the member can choose to self-direct services not provided by the facility can choose another provider for services that are optional from the facility.

Historically, members do not use 100% of their authorized waiver services. To ensure that the State or MCO does not spend more than what is historically spent for traditional waiver services, each service authorized under self-direction will have a utilization adjustment factor applied to it. This utilization adjustment factor is determined by an analysis of what percentage of authorized services has historically been used for each service on an aggregate by all members. The utilization factor is not based upon individual member usage, and all members have the same utilization factor applied. The utilization adjustment factor will be analyzed, at a minimum, every 12 months and adjusted as needed based historical use. This method will be used for all waiver members choosing the self-direction option. The monthly individual budget amount is based on the assessed needs of the member and the services and supports authorized in the member’s person-centered service plan. The member shall be informed of the individual budget amount during the development of the person-centered service plan.

The following is an example of how an individual budget is determined:

A member has a need for a particular service. On their traditional person-centered service plan, they are authorized 10 units of service at $20 a unit. That member decides that they would like to self-direct their services. The amount authorized is $200 in the traditional service plan. A utilization adjustment factor of 80% is applied. The member’s individual budget amount then becomes $160 ($200 X 80%). The 20% reduction (100% authorization minus 80% actual utilization for a service) is applied to allow for cost neutrality between the service under the traditional waiver plan and self-direction. If the average service utilization is only 80% of an authorized service under the traditional waiver, then a self-directed member is limited to that same 80% to preserve cost neutrality. The total monthly cost of all services (traditional and self-directed services) cannot exceed the established aggregate monthly cost of the traditional services authorized.

If there is a need that goes beyond the budget amount and/or the waiver service limit, the member has the right to request a Waiver of Iowa Administrative Rules. Waiver of Iowa Administrative Rules may be granted to the requestor when the member has needs beyond the limits expressed in the Iowa Administrative Code. This decision is made by the Director of HHS, based on an evaluation of the member's needs in relation to the State’s necessity to remain within the waiver’s parameters of cost neutrality. The process to request a Waiver of Iowa Administrative Rules is shared on the HHS website as well as with the member when they apply for waiver services. In addition, any member has the right to appeal any decision made by HHS and to request an appeal hearing by an administrative law judge. The member is afforded the opportunity to request a fair hearing when the budget adjustment is denied, or the amount of budget is reduced as described in F-1.

MCOs on their own and by their own determination, may make an exception to their own contractor policies. In the event an MCO denies an exception to policy and determines the member can no longer have his or her needs safely met through the 1915(c) waiver, the MCO is required to forward this information to HHS. In addition, MCO members have the right to appeal any decision made by the MCO and may appeal to the HHS once the MCO appeals process has been exhausted as described in F-1.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Members, regardless of delivery system (i.e., FFS members and MCO members), will be informed of their budget amount during the development of the person-centered service plan. The member can then make a final decision as to whether they want the self-direction option. If a member needs an adjustment to the budget, the member can request a review of the service plan.

As noted above, if there is a need that goes beyond the budget amount and/or the waiver service limit, the member has the right to request a Waiver to Administrative Rule. In addition, any member has the right to appeal any decision. The member is afforded the opportunity to request a fair hearing when the budget adjustment is denied, or the amount of budget is reduced as described in F-1.

MCO enrollees have the right to a State Fair Hearing after exhausting the MCO appeals process. It is the responsibility of the case manager to inform the member of the budget amount allowed for services before the service plan is completed.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

For both fee-for-service and MCO members, once the monthly budget amount has been established, the member will develop a detailed monthly budget that identifies the goods and services that will be purchased and the employees that will be hired to meet the assessed needs of the member. All services under the waiver are determined by the member's level of care assessment. The services determine a maximum budget, which is determined by the types of services assigned to self-direction.

The budget is sent to the FMS to identify what goods and services are approved for purchase and the employees that will be submitting timecards to the FMS for payment. The member can modify services and adjust dollar amounts among line items in the individual budget without changing the person-centered service plan as long as it does not exceed the authorized budget amount. They must submit a new budget to the FMS that identifies the changes. The FMS must receive all modifications to the individual budget within the month when the changes occur and will monitor the new budget to assure the changes do not exceed the authorized budget amount. The Individual Support Broker and the FMS will both monitor to assure expenses are allowable expenses.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Self-direction budgets are authorized monthly. Members, regardless of delivery system (i.e., FFS members and MCO members), can make adjustments at any time within the authorized amount if services are not meeting their needs, and the optional ISB via the FFS or MCO delivery system is available to provide assistance. The ISB also routinely monitors expenses. The FMS also monitors the budget and notifies the ISB and the member immediately if claims are inconsistent with the budgeted amount or if the budget is consistently underutilized. When members chose self-direction, they sign a consent form that explains their rights and responsibilities, including consequences for authorizing payments over the authorized budget amount.

The following safeguards are in place to prevent premature depletion of participant's budget:
• Member selects services to be self-directed from the person-centered service plan the case manager and member or legal representative create.
• HHS or the MCO authorizes those services in the person-centered service plan.
• Member or legal representative signs service plan to indicate agreement with the plan.
• Case manager identifies CCO budget amount and provides the amount to the member or legal representative and ISB if applicable.
• Member and the chosen ISB complete the CCO budget on the budget sheet, Form 470-4431.
• Member or legal representative signs the budget sheet to indicate understanding and agreement.
• Budget sheet is forwarded to the FMS prior to the month of service identified on the budget.
• FMS staffs a call center to respond timely to member, legal representative and ISB questions about processes and remaining budget balances.
• The amount included on the budget form cannot exceed the authorized budget amount.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

HCBS applicants and members have the right to appeal any adverse decision made by the Department. The information on how to file an appeal is posted on the HHS Appeals webpage: https://hhs.iowa.gov/programs/appeals.

Policies and procedures for State Fair hearings can be found in 441 IAC Chapter 7

All HHS member application forms, notices, pamphlets and brochures contain information on the appeals process and the opportunity to request an appeal. This information is available at all of the local offices. The process for filing an appeal can be found on all Notices of Decision (NOD) and Notices of Action (NOA). NODs and NOAs are issued anytime benefits or services are approved, denied, changed, or cancelled. An adverse benefit determination notice, that results in members' right to appeal, includes the following elements: the right to request a hearing, the procedure for requesting a hearing, the right to be represented by others at the hearing, unless otherwise specified by the statute or federal regulation, and how to obtain assistance, including the right to continue services while an appeal is pending. The member is encouraged, but not required, to make a written appeal on a standard Appeal and Request a Hearing form. Appeals may also be filed via the HHS website. Appeals may be made in person, by telephone, or in writing.

All notices are kept in the HHS member case file system, and the case manager's file. The member is given their appeal rights in writing, which explains their right to continue with their current services while the appeal is under consideration. Copies of all notices for a change in service are maintained in the service file. Iowa Medicaid reviews this information during case reviews.

When an HCBS member is assigned to a specific MCO, the assigned MCO community-based case manager explains the member's appeal rights through the Stat Fair Hearing process during the initial intake process. Members enrolled in an MCO must exhaust the entity's internal grievance processes before pursuing a State Fair Hearing.

MCO's give their members written notice of all adverse benefit determinations, not only service authorization adverse benefit determinations, in accordance with state and federal rules, regulations and policies, including but not limited to 42 CFR 438.402

MCO's shall mail the Notice of Adverse Benefit Determination at least ten (10) Days before the date of action, when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services. Members have 120 days from the date on the letter indicating the first-level review process has been exhausted. This requirement is outlined in the concurrent §1915(b) waiver, Part IV, Section E

MCO's Notice of Adverse Benefit Determination shall explain the reasons for the Adverse Benefit Determination, including the right of the Enrolled Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrolled Member's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. MCO's Notice of Adverse Benefit Determination shall explain the Enrolled Member's right to request an Appeal of the MCO's Adverse Benefit Determination, including information on exhausting the MCO's one (1) level of appeal and the right to request a State Fair Hearing after receiving Notice that the Adverse Benefit Determination is upheld.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

- **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The MCO grievance and appeals process operates in accordance with 42 CFR Part 438 Subpart F and is described in the concurrent 1915(b) waiver.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

• **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

FFS
Iowa Medicaid is responsible for operation of the complaint and grievance reporting process for all fee-for-service members. In addition, the Department maintains an HCBS QIO contract that is responsible for the handling of fee-for service member complaints and grievances in regard to provision of services under this waiver.

• **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Fee for Service grievances/complaints follow the parameters and timelines in accordance with 42 CFR 441.301(c)(7)(viii). Any fee-for-service waiver member, member's relative/guardian, agency staff, concerned citizen or other public agency staff may report a grievance/complaint regarding the care, treatment, and services provided to a member. A grievance/complaint may be submitted in writing, in person, by e-mail or by telephone. Verbal reports may require submission of a detailed written report. The grievance/complaint may be submitted to an HCBS QIO Specialist, HCBS Program Manager, any Iowa Medicaid Unit, or its leadership. Grievance/Complaints by phone can be made to a regional HCBS QIO Specialist at their local number or by calling Iowa Medicaid. Iowa Medicaid has established a HCBS quality committee to review HCBS performance which includes review of grievances and complaints.

Once received, the HCBS QIO shall initiate investigation within one business day of receipt and shall submit a findings report to the Quality Assurance Manager within 15 days of finalizing the investigation. Once approved by the Quality Assurance Manager, the findings report is provided to the complainant and the provider in question. If the complainant is a member, they are informed by the HCBS QIO Incident and Complaint Specialist that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing.

MCO grievances/complaints follow the parameters and timelines in accordance with 42 CFR 438.408 and 438.410.

A complaint means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested.

A grievance is a formal complaint by a HCBS member about the way that a service provider is furnishing a Medicaid service or about the conduct of a waiver administrative process.

A complaint is the formal expression of dissatisfaction by a HCBS member with the provision of a waiver service or the performance of an entity in conducting other activities associated with the operation of a waiver.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All waiver service providers, and case managers regardless of delivery system (i.e., FFS or managed care) are required to document major and minor incidents and make the incident reports and related documentation available to HHS upon request. Providers and case managers must also ensure cooperation in providing pertinent information regarding incidents as requested by HHS. MCOs must require that all internal staff and network providers report, respond to, and document critical incidents, as well as cooperate with any investigation conducted by the MCO or outside agency, all in accordance with State requirements for reporting incidents for 1915(c) HCBS Waivers, 1915(i) Habilitation Program, PMICs, and all other incidents required for licensure of programs through the Department of Inspections and Appeals.

Major incident is defined as an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and that:
• results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital,
• results in the death of the member, including those resulting from known and unknown medical conditions,
• results in emergency mental health treatment for the member, (EMS, Crisis Response, ER visit, Hospitalization)
• results in medical treatment for the member, (EMS, ER Visit, Hospitalization)
• results in the intervention of law enforcement, including contacts, arrests, and incarcerations,
• results in a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3,
• constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in bullets 1, 2, 3, 4, 5, and 6 above
• involves a member's provider staff, who are assigned protective oversight, being unable to locate the member or
• involves a member leaving the program against court orders, or professional advice
• involves the use of physical or chemical restraint or seclusion of the member

Child and dependent adult abuse is an inclusive definition that includes physical and sexual abuse, neglect and exploitation. Child abuse is defined in Iowa Code 232.68, and may include any of the following types of acts of willful or negligent acts or omissions:
- Any non-accidental physical injury.
- Any mental injury to a child's intellectual or psychological capacity.
- Commission of a sexual offense with or to a child.
- Failure on the part of a person responsible for the care of a child to provide adequate food, shelter, clothing or other care necessary for the child's health and welfare.
-The acts or omissions of a person responsible for the care of a child which allow, permit, or encourage the child to engage in prostitution.
- Presence of an illegal drug in a child's body as a direct act or omission of the person responsible for the care of a child or is using, manufacturing, cultivating, or distributing a dangerous substance in the presence of a child.
-The commission of bestiality in the presence of a minor.
-A person who is responsible for the care of a child knowingly allowing another person custody of, control over, or unsupervised access to a child under the age of fourteen or a child with a physical or mental disability, after knowing the other person is required to register or is on the sex offender registry. -The person responsible for the care of the child has knowingly allowed the child access to obscene material or has knowingly disseminated or exhibited such material to the child.
-The recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a child for the purpose of commercial sexual activity. Dependent adult abuse is defined in Iowa Code 235B.2, and may include any of the following types of acts of willful or negligent acts or omissions:
- Physical injury or unreasonable confinement, unreasonable punishment, or assault of a dependent adult. - Commission of a sexual offense or sexual exploitation.
- Exploitation of a dependent adult which means the act or process of taking unfair advantage of a dependent adult or the adult's physical or financial resources, without the informed consent of the dependent adult, including theft, by the use of undue influence, harassment, duress, deception, false representation, or false pretenses.
- Deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care or other care necessary to maintain a dependent adult's life or health.
-Personal degradation of a dependent adult by a caretaker. "Personal degradation" means a willful act or statement by a caretaker intended to shame, degrade, humiliate, or otherwise harm the personal dignity of a dependent adult, or where the caretaker knew or reasonably should have known the act or statement would cause shame, degradation, humiliation or harm to the personal dignity of a reasonable person.

Consistent with 441 Iowa Administrative Code 77, the following process is followed when a major incident occurs or a

staff member becomes aware of a major incident:
(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
a. The staff member's supervisor.
b. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to a guardian, if any, is always required.
c. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident by direct data entry into the Iowa Medicaid Provider Access (IMPA) System: https://hhs.iowa.gov/medicaid/provider-services/using-provider-portal

(3) The following information shall be reported:
a. The name of the member involved.
b. The date and time the incident occurred.
c. The date and time the incident discovered.
d. The date the report is made and the handwritten or electronic signature of the person making the report.
e. Incident type.
f. A description of the incident.
g. Root cause of the incident.
h. Immediate resolution of the incident.
i. Long term remediation of the incident of needed.
j. Date remediation was completed.

If the critical incident involves the report of child or dependent adult abuse, it is mandatory that this type of critical incident is reported to HHS Protective Services. If the critical incident does not involve child or dependent adult abuse, it will be reviewed by the MCO or HCBS QIO. The MCO will notify the member and/or the family of the results upon conclusion of the investigation, on or within 30 days. If the member is not with an MCO, the FFS case manager will notify the member, guardian, and or legal representative, verbally or in writing, of the results upon conclusion of the investigation, on or within 30 days.

As part of the quality assurance policies and procedures for HCBS Waivers, all incidents will be monitored and remediated by the HCBS Incident Reporting Specialist and HCBS specialists. On a quarterly basis, a QA committee will review data collected on incidents and will analyze data to determine trends, problems and issues in service delivery and make recommendations of any policy changes.

MCOs are also required to develop and implement a critical incident management system in accordance with HHS requirements, in addition to maintaining policies and procedures that address and respond to incidents, remediate the incidents to the individual level, report incidents to the appropriate entities per required timeframes, and track and analyze incidents. MCOs must adhere to the State's quality improvement strategy described in each HCBS waiver and waiver-specific methods for discovery and remediation.

MCOs must utilize system information to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. All MCO staff and network providers are required to:
- Report critical incidents.
- Respond to critical incidents.
- Document critical incidents.
- Cooperate with any investigation conducted by the HCBS QIO staff, MCO, or outside agency.
- Receive and provide training on critical incident policies and procedures.
- Be subject to corrective action as needed to ensure provider compliance with critical incident requirements.

Finally, MCOs must identify and track critical incidents, and review and analyze critical incidents, to identify and address quality of care and/or health and safety issues, including a regular review of the number and types of incidents and findings from investigations. This data should be used to develop strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information concerning protections from abuse, neglect and exploitation, including how to notify the appropriate authorities is provided to applicants and members at the time of application and at the time-of service plan development and annual review. During enrollment, and when any updates are made, HHS also provides to members a Medicaid Members Handbook, which contains information regarding filing a complaint or grievance. MCO written member enrollment materials also contain information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect.

In addition, information can also be found on HHS and MCO websites. The HHS website contains a “Report Abuse and Fraud” section, which describes how to report dependent adult child abuse. The same information is also available in written format in all of the local HHS offices, and members may also call Iowa Medicaid Member Services call center with any questions regarding filing a complaint or grievance.

Finally, each member’s risk factors will be assessed annually during the reevaluation process, as well as during the development of the person-centered service plan. HHS has developed training to ensure that case managers provide this information to members at a minimum on a yearly basis.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

HHS Protective Services (PS) receives all mandatory reports of child and dependent adult abuse. If an immediate threat of physical safety is believed to exist, PS makes every effort to examine that child or dependent adult within one hour of receipt and take any lawful action necessary. If the child or dependent adult is not in danger, PS makes every effort to examine the child or dependent adult within 24 hours. PS notifies the member's case manager when an investigation has been initiated to ensure they are aware of the alleged abuse, and to ensure that additional services can be added or that changes can be made to the member's plan of care if needed. PS provides an evaluation report within twenty days of receipt of the report, which includes necessary actions, and/or an assessment of services needed. The Central Registry of Abuse and County Attorney also receives PS reports. For both child and dependent adult abuse cases, the member and/or the family are notified of the results in writing by HHS as soon as the investigation has concluded. This applies to both individuals enrolled in fee-for-service or managed care.

If the incident is a situation that has caused, or is likely to cause a serious injury, impairment, or abuse to the member, and if PS has completed, or is in the process of conducting, an investigation the HCBS specialist coordinates activities with PS to ensure the safety of the member is addressed. If PS is not investigating, and immediate jeopardy remains, the member's case manager is notified immediately to coordinate services, and the HCBS Specialist initiates a review within two working days of receipt of the report. If it is determined that immediate jeopardy has been removed or not present, review by the HCBS Specialist is initiated within twenty working days of receipt of report. The HCBS Specialist prepares a report of findings within thirty days of the investigation being completed. These timelines apply to both individuals enrolled in fee-for-service or managed care.

The HCBS incident and complaint specialists refers any untimely, incomplete, or inaccurate CIR or CIR missing root cause, immediate resolution or long-term remediation to the reporter or the reporter's supervisor as applicable. A pattern or trend of issues, inappropriate or ineffective root causes, immediate resolutions, or long-term remediations may require follow-up technical assistance with the reporter or reporter's supervisor, as applicable. Patterns to look for include but are not limited to:
• Patterns in the timing of incidents (i.e., at transition times, evenings, mornings, when the member is unsupervised, mealtimes.)
• Patterns in root cause- events leading up to the incident or that may have caused the incident.
• Patterns in the type of incident or issue.
• Patterns in staff or others involved.

Technical assistance may be provided by the HCBS incident and complaint specialist or a regional HCBS specialist.

HHS meets monthly to review critical incident reports of child and dependent adult abuse and member deaths that have been reported through the critical incident reporting process. HHS reviews, and if needed, requests information for follow through and resolution of the abuse allegation and member deaths from the case manager or HCBS Specialist. Requests for information are forwarded to the case manager to verify any needed changes and confirm that follow-up has occurred with the member (i.e., changes to a plan of care or the safety or risk plan as necessary). If additional information or actions are required of a provider, the HCBS Specialist works directly with the provider to ensure that performance issues identified in the incident report are addressed. The HCBS Specialist uses the provider's Self-Assessment as the foundation of the review to assure that accuracy in the Self-Assessment and to identify any corrective actions that may be required. The HCBS Specialist generates a report of findings within thirty days of the completion of any review requiring corrective actions.

Information requests to the case manager or HCBS Specialist for follow up are tracked by the HCBS Unit on a weekly basis until the situation has been resolved. HHS utilizes a web-based critical incident reporting system to track and trend the discovery, remediation, and improvement of the critical incident reporting process. Revisions have been made to the system based on data collection and feedback from users, further enhancing the process. Incidents are reviewed by the HCBS QIO within one business day of report and forwarded to the case manager as needed to coordinate any follow-up and communication with the member, provider, and/or family/legal guardian. Incidents that lead to targeted review will initiate investigation by the HCBS QIO Unit within one business day. Findings reports are submitted to the QIO Manager within 15 days of investigation completion. Once the finding report is approved by the Quality Assurance Manager, the findings report is sent to the provider, case manager, or HCBS Specialist.

MCOs are responsible for developing and implementing critical incident management systems in accordance with the HHS requirements. Specifically, MCOs must maintain policies and procedures, subject to HHS review and approval, that: (1) address and respond to incidents; (2) report incidents to the appropriate entities per required timeframes; and (3)

track and analyze incidents. This information is utilized to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. Training must be provided to all internal staff and network providers regarding the appropriate procedures for reporting, responding to, and documenting critical incidents. Network providers must provide training to direct care staff regarding the appropriate procedures for reporting, responding to, and documenting critical incidents.

Finally, MCOs must identify and track, review and analyze critical incidents to identify and address quality of care and/or health and safety issues. MCOs must also regularly review the number and types of incidents and findings from investigations, in order to identify trends, patterns, and areas for improvement. Based on these findings, the MCO must develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. Consistent with 441 Iowa Administrative Code 77, the following process is followed when a major incident occurs or a staff member becomes aware of a major incident:
(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
a. The staff member's supervisor.
b. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to a guardian, if any, is always required.
c. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization and by completing the critical incident report form by direct data entry into the Iowa Medicaid Provider Access (IMPA) System.

(3) The following information shall be reported:
a. The name of the member involved.
b. The date and time the incident occurred.
c. A description of the incident.
d. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.
e. The action that the provider staff took to manage the incident.
f. The resolution of or follow-up to the incident.
g. The date the report is made and the handwritten or electronic signature of the person making the report.

If the critical incident involves the report of child or dependent adult abuse, it is mandatory that this type of critical incident is reported to HHS Protective Services. If the critical incident does not involve child or dependent adult abuse, it will be reviewed by the MCO. The MCO will notify the member and/or the family of the results upon conclusion of the investigation, on or within 30 days. If the member is not with an MCO, the FFS case manager will notify the member, guardian, and or legal representative, verbally or in writing, of the results upon conclusion of the investigation, on or within 30 days.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

HHS is responsible for overseeing the operation of the incident management system. The HCBS QIO reviews all critical incident reports as soon as they are reported to HHS. All critical incidents are tracked in the incident management system that tracks the elements as described above in G-1.d. If the incident has caused or is likely to cause a serious injury, impairment, or abuse to the member, and if PS has completed or is in the process of conducting an investigation, the HCBS Specialist will coordinate with PS. If PS is not investigating, the HCBS Specialist will begin an on-site review within two working days of receipt of the report. If it is determined that the member is not in immediate jeopardy, the review is initiated within twenty working days of receipt of report. For all other incidents, a review is initiated within twenty days. Critical incident data is compiled and analyzed aggregately to identify individual, provider and systemic remediation including the provision of training and technical assistance to prevent re-occurrences.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The HHS policy regarding restraints is as follows and applies to all types of restraints that may be used by waiver providers. The policy described in this section applies regardless of delivery system (i.e., FFS or MCO), and MCOs are contractually obligated to adhere.

Restraints include, but are not limited to, personal, chemical, and mechanical methods used for the purpose of controlling the free movement of an individual's body. Chemical restraints are most commonly used to calm an individual down in moments of escalation. Other examples of restraints include, but are not limited to, holding a person down with one's hands, tying an individual to a bed, using a straight jacket or demobilizing wrap. As a rights limitation, the restraint procedures must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of restraints must be documented in a member's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77, providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving HCBS shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

- The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
- Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
- Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
- Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
- Corporal punishment and verbal or physical abuse are prohibited.

These safeguards are the same regardless of what restraints are used. All restraints must also be consistent with applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with HHS to provide waiver services must conduct its activities in accordance with these requirements. Restraint procedures may be designed and implemented only for the safety of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a nonaversive program.

Physical and chemical restraints may be allowed depending on the provider's agency policy to ensure that there is an accompanying behavioral intervention plan, documentation of each instance, and monitoring of its use. These types of restraints must be considered on an individual basis after the interdisciplinary team reviews them, and entered into the written plan of care with specific timelines. If a member were placed in a closed room the timeframe would need to be determined on an individual basis and spelled out in the service plan. The provider would need to document the use of this restraint in the member's service file each time it was utilized by staff. The provider would be required to have a written policy approved by HHS on the supervision and monitoring of members placed in a closed room, for example monitoring on a fifteen-minute basis to assure the health and welfare of the member.

Restraint procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors, a Behavioral Intervention Program includes at least the following components:
- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will reinforced.

- A list of restraints and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Restraints and behavioral interventions may only be utilized to teach replacement behaviors when nonaversive methods of positive support have been ineffective.

- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. Staff must be trained and exhibit proficiency as described below before administering restraints. An employee's ability to implement a procedure must be documented in one of the following ways:
- A program staff person may observe each employee in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (i) the supervisor's ability to implement the procedure has been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Restraints and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter a member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements:
- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the member's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the individual and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:
- A Restraint and Behavioral Intervention Program that is a part of the written individual service plan developed by the member's case manager and in the provider plan of care developed for the member.
- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as, and includes, the following components: (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior; (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors; (iii) description of the conditions that precede the behavior in question; (iv) description of what appears to reinforce and maintain the behavior; and (v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Restraints must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the

written plan of care with specific timelines. All restraints are explained to the member and their legal representative and agreed upon ahead of time.

Unauthorized use of restraints would be detected via:
- interviews with the member, their family and staff and case manager;
- review of critical incident reports by HHS and member's case manager;
- review of written documentation authored by provider staff;
- annual review activities associated with the provider quality oversight processes;
- the complaints and grievance processes.

Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the HHS policy for each type of agency identified restraint is observed and member rights are safeguarded. If it is found that a waiver provider is not observing HHS policy or ensuring a member's rights, adverse action is taken by Iowa Medicaid, which may include sanction, termination, required corrective action, etc.

The member's case manager is responsible to monitor individual plans of care including the use of restraints and behavioral interventions.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The first line of responsibility for overseeing the use of restraints and ensuring safeguards are in place is the member's case manager. The use of restraints must be assessed as needed and identified in the individual member's person-centered service plan. The use of restraints would also require the development and implementation of a behavior plan, and the plan would be included in the member's person-centered service plan. The case manager is responsible for monitoring to assure that supports and services in the service plan are being implemented as identified. Any issues with the use of restraints would be addressed with the provider of service and corrected as needed.

The State also contracts with the HCBS QIO to oversee the appropriateness, provider policies and procedures, and service plan components associated with restraints. The HCBS QIO conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the HCBS QIO examines member files, and conducts targeted reviews based on complaints, to ascertain whether restraints are appropriately incorporated into the service plan, such that restraints are only implemented as designated in the plan (who, what, when, where, why, and how). If the HCBS QIO discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PI and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit critical incident reports. Categories within the incident report include inappropriate use of restraints. These reports are entered into IMPA. If it is found that the incident demands further investigation, the issue is passed to the HCBS QIO for a targeted review. If the HCBS QIO discovers that the provider is less than compliant in areas surrounding the use of restraints, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PI and possible sanctions (suspension, probation, termination, etc.) may apply.

The HCBS QIO compiles all data related to incidents reported in IMPA associated with the inappropriate use of restraints, as well as data from periodic and targeted provider reviews conducted by the HCBS QIO. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to HHS. Trends are used, along with those established in the monthly HCBS QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

In addition, MCOs must identify and track critical (major) incidents, regularly review the number and types of incidents and findings from investigations and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77 for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS QIO, critical incident review, etc.)

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

A restrictive intervention is an action or procedure that imposes a restriction of movement, that limits a member's movement, access to other individuals, locations or activities, or restricts a member's rights. 441-IAC Chapter 77 describes restrictive interventions as restraints, restrictions and behavioral intervention.

The HHS policy regarding restrictive interventions is as follows and applies to all types of restrictions that may be used by waiver providers. A restrictive intervention is an action or procedure that limits a member's movement, access to other individuals, locations or activities, or restricts a member's rights. The use of any restrictive interventions as part of the waiver program is treated as rights limitations of the member receiving services. As a rights limitation, the restrictive interventions must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code 83.).

Per 441 Iowa Administrative Code Chapter 77., "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures." All members receiving HCBS shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.
a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time-of-service approval and as changes occur.
b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
e. Corporal punishment and verbal or physical abuse are prohibited."

These safeguards are the same regardless of what restrictions are used. All restrictions must also be consistent with applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with HHS to provide waiver services must conduct its activities in accordance with these requirements. Restrictions may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a nonaversive program.

The case manager, or community-based case manager has the responsibility to assess the need for the restrictive interventions, identify the specific restrictive intervention, explain why the intervention is being used, identify an intervention plan, monitor the use of the restrictive intervention, and assess and reassess need for continued use. The service plan authorizes the services to be delivered to the member and identifies how they are to be provided. Without the authorization, services cannot be provided to a member.

Providers are required to use the service plan as the basis for the development and implementation of the providers' treatment plan. The provider is responsible for developing a plan to meet the needs of the member and to train all staff on the implementation strategies of the treatment plan, such that the interventions are individualized and in accordance with the previously devised plan. Providers and the case manager are responsible for documenting all behavioral interventions, including restrictive interventions, in the service plan as well as the member's response to the intervention. Providers and case manager are also required to submit critical incident reports via the critical incident management system in IMPA, any time a restrictive intervention is utilized.

Providers are required to maintain a system for the review, approval and implementation of ethical, safe, humane and efficient behavioral intervention procedures, that inform the member and his/her legal guardian of the behavioral intervention policy and procedures at the time of entry into a facility and as changes occur. Non-aversive methods of intervention must be designed and utilized as the option of first use, prior to design or implementation of any behavioral intervention containing aversive techniques. Behavioral intervention procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a nonaversive program.

Behavioral intervention procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. Corporal punishment and verbal or physical abuse are prohibited. Restrictions may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors, a Behavioral Intervention Program includes at least the following components:
- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of restrictions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Restrictions and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. A person's ability to implement a procedure must be documented in one of the following ways:
- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (i) the supervisor's ability to implement the procedure has been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter a member's behaviors.

Restrictions and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter a member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements:
- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the member's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the member and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the Behavioral Intervention Program must include:
- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as, and includes, the following components:
(i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;
(ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which

includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;
(iii) description of the conditions that precede the behavior in question;
(iv) description of what appears to reinforce and maintain the behavior; and
(v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Restrictions must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific timelines. All restrictions are explained to the member and their legal representative and agreed upon ahead of time. Unauthorized use of restrictions would be detected via interviews with the member, their family and staff and case manager; through review of critical incident reports by HHS and member's case manager; HHS and case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider quality oversight processes; and by reports from any interested party (complaints).

Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the HHS policy for each type of agency identified restriction is observed and member rights are safeguarded. If it is found that a waiver provider is not observing HHS policy or ensuring a member's rights, adverse action is taken by Iowa Medicaid, which may include sanction, termination, required corrective action, etc.

The member's case manager is responsible to monitor individual plans of care including the use of restrictions and behavioral interventions.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

A restrictive intervention is an action or procedure that imposes a restriction of movement, that limits a participant's movement, access to other individuals, locations or activities, or restricts a participant's rights. 441-IAC chapter 77 describes restrictive interventions as restraints, restrictions and behavioral intervention. Per the description of restrictive interventions noted in the application (G-2-b-i) above, Iowa will need to review its inclusion of restraint as a restrictive intervention.

The first line of responsibility for overseeing the use of restrictive interventions and ensuring safeguards are in place is the member's case manager. The use of restrictive interventions must be assessed as needed and identified in the individual member's service plan. The use of restrictions would also require the development and implementation of a restrictive intervention plan and the plan would be included in the participant's service plan. The member's case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restrictive interventions would be addressed with the provider of service and corrected as needed.

The State contracts with the HCBS QIO to oversee the appropriateness, provider policies and procedures, and service plan components associated with restrictions. The HCBS QIO conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the HCBS QIO examines member files, and conducts targeted reviews based on complaints, to ascertain whether restrictions are appropriately incorporated into the service plan, such that restrictions are only implemented as designated in the plan (who, what, when, where, why, and how). If the HCBS QIO discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PI and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers, regardless of if serving FFS or MCO members, are required to submit major incident reports. Categories within the incident report include inappropriate use of restrictions.

Provider reports of restrictive interventions are entered as a critical incident into IMPA, which trigger milestones in IoWANS for fee-for-service members. These triggers alert case managers and prompt Iowa Medicaid HCBS Incident Reporting Specialist to conduct a review of the restrictive intervention. If it is found that the restrictive intervention demands further investigation, the issue is passed to the HCBS QIO for a targeted review. If the HCBS QIO discovers that the provider is less than compliant in areas surrounding the use of restrictions, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to the Iowa Medicaid Program Integrity Unit for possible sanctions that may apply.

For MCO members, the MCO receives a nightly report out of the critical incident management system of all critical incident reports for their enrollees. In the MCO system and processes, MCO CBCMs are alerted along with the MCO Critical Incident Reporting Specialist to conduct a review of the restrictive intervention. Processes for targeted review, provider corrective actions and PI referral, if warranted, are followed as discussed in the FFS process.

Finally, the HCBS QIO compiles all data related to incidents associated with the inappropriate use of restrictions, as well as data from periodic and targeted provider reviews. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to HHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules. MCO Community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restrictive interventions would be addressed with the provider of service and corrected as needed. In addition, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code Chapter 77 for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the waiver submission (i.e., HCBS QIO, critical incident review, etc.).

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver policy regarding the use of seclusion comport with the home and community-based setting requirements at Section 42 CFR 441.301(c)(4)(iii) and (vi)(F), and person-centered service planning and plan requirements at 42 CFR 441.301(c)(1) and (c)(2).

The HHS policy regarding seclusion is as follows and applies to all types of seclusions that may be used by waiver providers, regardless of delivery system (i.e., FFS or MCO). Examples of seclusion include but are not limited to locking a member in a room, locking a member out of an area of their residence, or limiting community time. All incidents of seclusion must be documented in the member's service record and reported to Iowa Medicaid as a critical incident. As a rights limitation, the seclusion procedures must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of seclusion must be documented in a member's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77, providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures." All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.
a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
e. Corporal punishment and verbal or physical abuse are prohibited.

The same standard is used for seclusion as a restrictive intervention. All seclusions must also be consistent with applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with HHS to provide waiver services must conduct its activities in accordance with these requirements.

Seclusion procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a nonaversive program. Seclusion may be allowed depending on the provider's agency policy to ensure that there is an accompanying behavioral intervention plan, documentation of each instance, and monitoring of its use. Seclusion can be considered on an individual basis after the interdisciplinary team reviews them and are entered into the written plan of care with specific timelines. If a member were placed in a closed room, the time frame would need to be determined on an individual basis and spelled out in the service plan. The provider would need to document the use of this seclusion in the member's service file each time it was utilized by staff. The provider would be required to have a written policy approved by HHS on the supervision and monitoring of members placed in a closed room, such as monitoring on a fifteen-minute basis to assure the health and welfare of the member.

Seclusion procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors, a Behavioral Intervention Program includes at least the following components:
- A clear objective description of the maladaptive target behavior to be reduced or eliminated. - A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of seclusions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Seclusions and behavioral interventions may only be utilized to teach replacement behaviors when nonaversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. A person's ability to implement a procedure must be documented in one of the following ways:
- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met:
(i) the supervisor's ability to implement the procedure has been documented by a program staff person.
(ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and
(iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Seclusion and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter an member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member service plan and the case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements.
- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the person's maladaptive target behavior. - Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the individual and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:
- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as and includes the following components:
(i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;
(ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;
(iii) description of the conditions that precede the behavior in question;
(iv) description of what appears to reinforce and maintain the behavior; and
(v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Seclusions must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific timelines. All seclusions are explained to the member and their legal

representative and agreed upon ahead of time.

Unauthorized use of seclusion would be detected via interviews with the member, their family and staff and case manager; through review of critical incident reports by HHS and member's manager on a daily basis; HHS and case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints). Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the HHS policy for each type of agency identified seclusion is observed and member rights are safeguarded. If it is found that a waiver provider is not observing HHS policy or ensuring a member's rights, adverse action is taken by Iowa Medicaid, which may include sanction, termination, required corrective action, etc.

The member's manager is responsible to monitor individual plans of care including the use of seclusion and behavioral interventions.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The first line of responsibility for overseeing the use of seclusion and ensuring safeguards are in place is the member's case manager. The use of seclusion must be assessed as needed and identified in the individual member's person-centered service plan. The use of seclusion would also require the development and implementation of a behavior plan and the plan would be included in the member's person-centered service plan. The case manager is responsible for monitoring to assure that supports and services in the service plan are being implemented as identified. Any issues with the use of seclusion would be addressed with the provider of service and corrected as needed.

The State contracts with the HCBS QIO to oversee the appropriateness, provider policies and procedures, and service plan components associated with seclusion. The HCBS QIO conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the HCBS QIO examines member files, and conducts targeted reviews based on complaints, to ascertain whether seclusion is appropriately incorporated into the service plan, such that seclusion is only implemented as designated in the plan (who, what, when, where, why, and how). If the HCBS QIO discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PI and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of seclusion. These reports are entered into IMPA, trigger milestones in IoWANS for fee-for-service members that alert case managers and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the HCBS QIO for a targeted review. If the HCBS QIO discovers that the provider is less than compliant in areas surrounding the use of seclusion, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PI and possible sanctions (suspension, probation, termination, etc.) may apply.

Finally, HCBS QIO compiles all data related to incidents reported in IMPA associated with the inappropriate use of seclusion, as well as data from periodic and targeted provider reviews conducted by the HCBS QIO. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to HHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The case manager, and any provider responsible for medication administration must monitor the documentation of medication administration to ensure adherence to the service plan and provider policies and procedure. The provider agency frequently and routinely monitors as outlined in their policies and procedures, and quality improvement plans. Provider agencies are expected to review medication administration on a daily basis to ensure health and welfare of member as well as perform quality assurance on a timeframe identified by the agency (most often monthly). The case manager also monitors during the annual service plan development. Case managers monitor the documentation of medication administration to ensure adherence to the service plan and provider policies and procedures.

Monitoring includes review of the service documentation to ensure that medications have been administered at the designated times and by designated individuals. Further monitoring occurs through the report of major incidents whenever a medication error results in physicians' treatment, mental health intervention, law enforcement intervention, death, or elopement. When a major incident has occurred, follow-up, investigation, and remediation occurs as identified in G.l.d. All medication errors resulting in a major incident report or discovered via complaint are fully investigated. If it is determined that a harmful practice has been detected, the provider agency completes a corrective action plan and may face sanctions depending on severity and negligence of the circumstance.

The Iowa Medicaid program has actively managed Medicaid pharmacy benefits through a uniform Preferred Drug List (PDL) and uniform prior authorization guidelines since 2005. A governor appointed medical assistance pharmaceutical and therapeutics (P&T) committee was established for the purpose of developing and providing ongoing review of the PDL. The pharmacy prior authorization departments of Iowa Medicaid FFS and MCOs utilizes the PDL and prior authorization guidelines to review medication management.

The Department of Inspections and Appeals and Licensing (DIAL) is responsible for Medicaid member's medication regimes for waiver members served in a Residential Care Facility (RCF). All medical regimes are included in the member's record. Medications administered by the facility are recorded on a medical record by the individual who administers medication. All RCFs are licensed facilities and must meet all DIAL's Administrative Rules to obtain an annually renewable license. Medical records are reviewed during licensure renewal. Persons administrating medication must be a licensed nurse or physician or have successfully completed a department approved medication aide course. If the provider stores, handles, prescribes, dispenses, or administers prescription or over the counter medications the provider is required to develop procedures for the storage, handling, prescribing, dispensing, or administration of medication. For controlled substances, providers must maintain DIAL procedures. If the provider has a physician on staff or under contract, the physician must review and document the provider's prescribed medication regime at least annually in accordance with current medical practice. Policies and procedures must be developed in written form by the provider for the dispensing, storage, and recording of all prescription and nonprescription medications administered, monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, including antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics. Policies and procedures are reviewed by the HCBS Specialists for compliance with state and federal regulations. If deficiencies are found, the provider is required to submit a corrective action, and follow-up surveys may be conducted based on the severity of the deficiency.

Per 441 Iowa Administrative Code Chapter 77, respite providers must meet the following requirements as a condition of providing respite care under the waiver: (1) training on provision of medication according to agency policy and procedure; and (2) the staff member shall not provide any direct service without the oversight of supervisory staff until training is completed.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Second line responsibility is utilized when issues are more complex. Occurrences of high dosage use for certain medications or prescribing drugs for an age group where the drug is not FDA indicated are sent to Iowa Medicaid for review. In some cases, edits have been placed in the computer system so the prescriber could not prescribe for age groups not indicated.

Drug Utilization Review (DUR) Commission: DUR is a second line monitoring process with oversight by HHS. The DUR system includes a process of provider intervention that promotes quality assurance of care, patient safety, provider education, cost effectiveness and positive provider relations. Letters to providers generated as a result of the professional evaluation process identify concerns about medication regimens and specific patients. At least one Iowa licensed pharmacist is available to reply in writing to questions submitted by providers regarding provider correspondence, to communicate by telephone with providers as necessary and to coordinate face-to-face interventions as determined by the DUR.

The Department of Inspections and Appeals and Licensing (DIAL): DIAL is responsible for oversight of licensed facilities. DIAL communicates all findings to HHS and any issues identified during the RCF/ID licensure process, or critical incidents as they arise. DIAL tracks information and provides training as necessary to improve quality. This information is also shared with HHS. Both DIAL and HHS follow-up with identified RCF/IDs to assure that action steps have been made to ensure potential harmful practices do not reoccur.

HCBS QIO Unit: HHS contracts with the HCBS QIO to oversee provider policies and procedures and service plan components associated with medication management. The HCBS QIO conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. The HCBS QIO examines member files and conducts targeted reviews based on complaints to ascertain whether medications are appropriately incorporated into the service plan. If the HCBS QIO discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PI and possible sanctions (suspension, probation, termination, etc.) may apply.

With respect to MCO members, community-based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of medication would be addressed with the provider of service and corrected as needed. In addition, MCOs must maintain documentation of the member’s medication management done by the MCOs clinical staff; monitor the prescribing patterns of network prescribers to improve the quality of care coordination services provided to members through strategies such as: (a) identifying medication utilization that deviates from current clinical practice guidelines; (b) identifying members whose utilization of controlled substances warrants intervention; (c) providing education, support and technical assistance to providers; and (d) monitor the prescribing patterns of psychotropic medication to children, including children in foster care. Finally, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code Chapter 77 for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS QIO, critical incident review, etc.).

All waiver service providers are required to submit major incident reports. Categories within the incident report include medication errors. These reports are entered into IMPA, trigger milestones in IoWANS for fee-for-service members that alert case managers and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the HCBS QIO for a targeted review. If the HCBS QIO discovers that the provider is less than compliant in areas surrounding medication management, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PI and possible sanctions (suspension, probation, termination, etc.) may apply.

The HCBS QIO compiles all data related to incidents reported in IMPA associated with the inappropriate use of medication, as well as data from periodic and targeted provider reviews conducted by the HCBS QIO. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to HHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational

Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

• **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Supported community living, supported employment, and respite service providers must have policies and procedures developed for dispensing, storage, and recording all prescription and nonprescription medication administered. 441 Iowa Administrative Code Chapter 77 requires: Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered.

Providers are required to have staff trained on medication administration and provide safe oversight of medication administration. The State does not require specific medication administration curriculum to be used. Providers are responsible to assure that staff has the skills needed to administer medications safely. There are no uniform requirements in the Iowa Administrative Code for the provision of medication administration or for the self-administration of medications by Medicaid members.

The Provider Quality Self-Assessment process requires providers to have a policy and procedure for the storage and administration of medication. This process requires a more uniform approach for the provider in the requirements for medication management. The Provider Quality Self-Assessment review checklist used by the HCBS QIO Specialist to review providers identifies the following minimum standards that the medication policy will identify:
- The provider’s role in the management and/or administration of medications
- If staff administers medications, the policy will identify the: (1) training provided to staff prior to the administration of medications; (2) method of documenting the administration of medications; (3) storage of medications; (4) the assessment process used to determine the Medicaid member’s role in the administration of medications.

The Provider Quality Self-Assessment process also requires providers to have discovery, remediation and improvement processes for medication administration. The information and results of these activities is available to HHS upon request.

Home Health agencies that provide waiver services must follow Medicare regulations for medication administration and dispensing. All medications must be stored in their original containers with the accompanying physician's or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to those who do not need access. Nonprescription medications shall be labeled with the Medicaid member's name. In the case of medications that are administered on an ongoing long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription. All providers of respite must develop policies that assure that personnel that administer medications have the appropriate skills and that there is oversight by medical personnel. Provider non-medical waiver staff that administers medications must have oversight of a licensed nurse. If the medication requires, the staff is required to complete a medication management course through a community college.

The requirements for non-medical waiver providers must have in order to administer medications to Medicaid members who cannot self-administer is that the provider must have a written policy in place on what the requirements are for their staff to do this and how. If the medications are psychiatric medications the person would have to have successfully completed a medication aide class. Oversight for a staff member who administers medications that require oversight such as in the case of psychiatric medications would need to follow the requirements as spelled out through the Board of Nursing such as having oversight by a registered nurse. The HCBS QIO Specialists would oversee this policy during regular reviews of the provider.

State oversight responsibility is described in Appendix H for the monitoring methods that include identification of problems in provider performance and support follow-up remediation actions and quality improvement activities.

- **Medication Error Reporting.** *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Providers are required to complete incidents reports for all occurrences meeting the criteria for major and minor incidents and make the incident reports and related documentation available to HHS upon request. Major incidents must be reported to the Iowa Medicaid via IMPA. Providers must ensure cooperation in providing pertinent information regarding incidents as requested by HHS.

As part of the major incident reporting process described in Appendix G-1, HHS will review and follow-up on all medication errors that lead to a member hospitalization or death. This can include the wrong dosage, the wrong medication delivered, medication delivered at the wrong time, medication administration delivery not documented, unauthorized administration of medication, or missed dosage. Providers are required to submit all medication errors, whether major or minor, to the member's case manager or community-based case manager when they occur. The case manager or community-based case manager monitors the errors and makes changes to the member’s service plan as needed to assure the health and safety of the member.

The Provider Quality Self-Assessment process requires providers to have a policy and procedure regarding medication administration and medication management. The Provider Quality Self-Assessment process also requires that providers have discovery, remediation, and improvement processes for medication administration and medication errors. Specifically, providers are required to have ongoing review of medication management and administration to ensure that medications are managed and administered appropriately. Providers are also required to track and trend all medication errors to assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to HHS upon request and will be reviewed as part of the ongoing Provider Quality Self-Assessment process conducted by the HCBS QIO Specialists. This will include random sampling of providers, incident specific review (complaint and IR follow up) and on-site provider review held every five years.

Other professionals or family members may report medication error incidents at any time as a complaint. Suspected abuse is reported to the reporting hotline operated by the Department of Health and Human Services.

(b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record all medication errors, both major and minor, that occur. Providers are required to track and trend all medication errors and assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to HHS upon request and will be reviewed as part of the ongoing Provider Quality Self-Assessment and certification review processes conducted by the HCBS Specialists.

Major incident is defined as an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and that:
• results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital,
• results in the death of the member, including those resulting from known and unknown medical conditions,
• results in emergency mental health treatment for the member, (EMS, Crisis Response, ER visit, Hospitalization)
• results in medical treatment for the member, (EMS, ER Visit, Hospitalization)
• results in the intervention of law enforcement, including contacts, arrests, and incarcerations,
• results in a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3,
• constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in bullets 1, 2, 3, 4, 5, and 6 above
• involves a member's provider staff, who are assigned protective oversight, being unable to locate the member or
• involves a member leaving the program against court orders, or professional advice
• involves the use of physical or chemical restraint or seclusion of the member

All major incidents must be reported by the next calendar day following the incident or discovering an incident has occurred, using Iowa Medicaid's Iowa Medicaid Portal Access (IMPA) System.

Per Chapter 441 Iowa Administrative Code chapter 77 a medication error is included in the definition of "minor incidents" Providers are not required to report minor incidents to HHS. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the participant's file.

(c) Specify the types of medication errors that providers must *report* to the state:

Only major incidents of medication errors that result in physical injury, death, emergency mental health treatment, medical treatment, law enforcement intervention, or a report of child or dependent adult abuse of the member, as defined by the major incident criteria, are required to be reported to HHS.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Iowa Medicaid is responsible for the oversight of waiver providers in the administration of medications to waiver members. Oversight monitoring is completed through IMPA, the Provider Quality Self-Assessment process and monitoring of the participant by the member's case manager or community-based case manager. With respect to MCO members, community-based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of medication would be addressed with the provider of service and corrected as needed. In addition, MCOs must maintain documentation of the member's medication management done by the MCOs clinical staff; monitor the prescribing patterns of network prescribers to improve the quality-of-care coordination services provided to members through strategies such as:
(a) identifying medication utilization that deviates from current clinical practice guidelines;
(b) identifying members whose utilization of controlled substances warrants intervention;
(c) providing education, support and technical assistance to providers; and
(d) monitor the prescribing patterns of psychotropic medication to children, including children in foster care.

Finally, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code Chapter 77 for reporting major incidents. HHS maintains ultimate oversight through the mechanisms identified (i.e., HCBS QIO, critical incident review, etc.). All of these processes have been described in detail in this Appendix.

All medication errors are considered either major or minor incidents, as noted in Subsection "iii.b" above. Major incidents are reported to the department and follow the incident reporting follow up protocol of the department.

HHS contracts with the HCBS QIO to oversee provider policies and procedures and service plan components associated with medication management. The HCBS QIO conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and Federal rule, regulations, and best practices. Further, HCBS QIO examines member files, and conducts targeted reviews based on complaints, to ascertain whether medications are appropriately incorporated into the service plan. If the HCBS QIO discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to the Program Integrity unit for possible sanctions (suspension, probation, termination, etc.).

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate medication administration. These reports are entered into IMPA, trigger milestones in IoWANS for fee-for-service members that alert case managers and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding medication administration, the provider is required to complete a CAP and implement the CAP to 100% compliance. Again, if it is found that the circumstances are more serious, recommendations are made to the Program Integrity unit for possible sanctions (suspension, probation, termination, etc.).

The HCBS QIO compiles all data related to incidents reported in IMPA associated with the inappropriate medication administration, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to Iowa Medicaid. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of information and changes to policy as needed.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis,*

identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
HW-a1: Number and percent of IAC-defined major critical incidents requiring follow-up escalation that were investigated as required. Numerator: number IAC-defined major critical incidents requiring follow-up escalation that were investigated as required; Denominator: number of IAC-defined major critical incidents requiring follow-up escalation.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
HW-a2: Number and percent of Critical Incident Reports (CIRs) including alleged abuse, neglect, exploitation, or unexplained death that were followed up on as required. Numerator: # of CIRs including alleged abuse, neglect, exploitation, or unexplained death that were followed up on as required; Denominator: # of CIRs that included alleged abuse, neglect, exploitation, or unexplained death.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data 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:
HW-a3: Number and percent of member service plans that indicate the member received information on how to identify and report abuse, neglect, exploitation and unexplained deaths. Numerator: #of members service plans that indicate the members received information on how to identify and report abuse, neglect, exploitation and unexplained deaths. Denominator: Total # of member service plans reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted entity including MCO	☐ **Annually**	☒ **Stratified** Describe Group:

		IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
HW-b1: Number and percent of unresolved critical incidents that resulted in a targeted review that were appropriately resolved. Numerator: number of unresolved critical incidents that resulted in a targeted review that were appropriately resolved; Denominator: number of unresolved critical incidents that resulted in a targeted review.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
HW-b2: Number and percent of critical incidents where root cause was identified.
Numerator: Number of critical incidents where root cause was identified.
Denominator: # of Critical Incident Reports

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☒ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

HW-b3: Number and percent of emergency room visits that meet the definition of a CI where a CIR was submitted. Numerator: Number emergency room visits, that meet the definition of a CI, where a CIR was submitted; Denominator: Number of emergency room visits meeting the definition of CI.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS submitted claims and Critical events and incident reports.

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
HW-c1: Number and percent of providers that met the requirements for the use of restraint, restriction, or behavioral intervention programs with restrictive procedures. Numerator: number providers that met the requirements for use of restraint, restriction, or behavioral intervention programs with restrictive procedure; Denominator: total number of reviewed providers.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
HW-d1: Number and percent of waiver members who received care from a primary care physician in the last 12 months. Numerator: Number of waiver members who received care from a primary care physician in the last 12 months; Denominator: Number of waiver members reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Claims Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☒ **Other**	☒ **Annually**	☒ **Stratified**

Specify: Contracted Entity		Describe Group: IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

The HCBS QIO and each MCO are responsible for monitoring and analyzing data associated with the major incidents reported for members on waivers. Data is pulled from the data warehouse and from MCO reporting on a regular basis for programmatic trends, individual issues and operational concerns. Reported incidents of abuse, medication error, death, rights restrictions, and restraints are investigated further by the HCBS Incident Reporting Specialist as each report is received. The analysis of this data is presented to the state on a quarterly basis.

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.

The HCBS Quality Oversight Unit (QIO) and MCOs are also responsible for conducting the HCBS CAHPS survey with waiver participants. The HCBS QIO or MCO conduct interviews either face-to-face or via telephone, to the discretion of the member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis. The HCBS Specialists conducting CAHPS interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. MCO are responsible for research and follow up to flagged responses. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes to provider policy.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Iowa Department of Health and Human Services is the single state agency that retains administrative authority of Iowa's HCBS Waivers. Iowa remains highly committed to continually improve the quality of services for all waiver programs.

The QIS developed by Iowa consolidates and stratifies performance data across the five 1915(c) waivers that will be in effect on October 1, 2026. The HCBS waiver population will be identified based on waiver enrollment at a single point in time. A 95% confidence level with a 5% error rate for the total waiver population is calculated. In an effort to ensure each waiver is represented within the sample identified for the reporting year, the specific waiver enrollment will be divided by the total waiver population to identify the percentage the specific waiver contributes to the overall waiver population during that reporting year. The significant sample will be multiplied by the percentage identified for each waiver to identify the number of surveys/reviews that need to be completed for each waiver. This process is completed for each waiver to ensure that the 95% confidence level is met and that each waiver is appropriately sampled. A common capture date will be used to count enrollment numbers for all waivers.

IA. Adult and Disability Waiver 8%
IA. Child and Youth Waiver 8%
IA. Elderly Waiver 29%
IA. Intellectual Disabilities Waiver 49%
IA. Brain Injury Waiver 6%

Based on contract oversight and performance measure implementation, Iowa Medicaid holds regularly occurring meetings to review and discuss performance data to identify areas of noted concern for assessment and prioritization. This can include discussion of the discovery and remediation activities at an individual, programmatic and systemic level. These activities may lead to operational changes. Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and ongoing quality improvement. Further, a quality assurance committee meets monthly to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level.

All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas. The QM/QI program must have objectives that are measurable, realistic and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 Subpart E and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program. The State has developed a reporting manual for the MCOs to utilize for many of the managed care contract monthly and quarterly reporting requirements. The managed care contract also allows for the State to request additional regular and ad hoc reports.

HHS is in the process of implementing quality management system improvements, which will enable data to be captured at a more refined level, specifically individual discovery remediation. While each contracting unit utilizes their own electronic tracking system or OnBase (workflow management), further improvements are in process to ensure the effectiveness of the improvement initiatives.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☒ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: Contracted Entity, including MCOs	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Iowa Medicaid employs a Quality Assurance Manager to oversee the data compilation and remediation activities associated with 1915(c) performance measures. The QA Manager and State policy staff address oversight of design changes and the subsequent monitoring and analysis during the bi-weekly policy and monthly quality assurance meetings. Prior to dramatic system design changes, the State will seek the input of stakeholders and test/pilot changes that are suggested and developed. Informational letters are sent out to all relevant parties prior to implementation with contact information of key staff involved. This workflow is documented in logs and in informational letters found within the HHS computer server for future reference. Stakeholder involvement and informational letters are requested or sent out on a weekly/monthly/ongoing basis as policy engages in the continuous quality improvement cycle.

Unit managers, policy staff and the QA committee continue to meet on a regular basis (weekly or monthly) to monitor performance and work plan activities. Iowa Medicaid Management and QA committees include representatives from the contracted units within Iowa Medicaid as well as State staff. These meetings serve to present and analyze data to determine patterns, trends, concerns, and issues in service delivery of Medicaid services, including by not limited to waiver services. Based on these analyses, recommendations for changes in policy are made to the Iowa Medicaid policy staff and bureau chiefs. This information is also used to provide training, technical assistance, corrective action, and other activities. The unit managers and committees monitor training and technical assistance activities to assure consistent implementation statewide. Meeting minutes/work plans track data analysis, recommendations, and prioritizations to map the continuous evaluation and improvement of the system. Iowa Medicaid analyzes general system performance through the management of contract performance benchmarks, IoWANS reports, and contract deliverables and then works with contractors, providers and other agencies regarding specific issues. The QA committee directs workgroups on specific activities of quality improvement and other workgroups are activated as needed.

In addition to developing QM/QI programs that include regular, ongoing assessment of services provided to Medicaid beneficiaries, MCOs must maintain a QM/QI Committee that includes medical, behavioral health, and long-term care staff, and network providers. This committee is responsible for analyzing and evaluating the result of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action, and ensuring appropriate follow-up. This committee is also responsible for reviewing and approving the MCO’s QM/QI program description, annual evaluation, and associated work plan prior to submission to HHS.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Iowa Medicaid reviews the overall QIS no less than annually. Strategies are continually adapted to establish and sustain better performance through improvements in skills, processes, and products. Evaluating and sustaining progress toward system goals is an ongoing, creative process that has to involve all stakeholders in the system. Improvement requires structures, processes, and a culture that encourage input from members at all levels within the system, sophisticated and thoughtful use of data, open discussions among people with a variety of perspectives, reasonable risk-taking, and a commitment to continuous learning. The QIS is often revisited more often due to the dynamic nature of Medicaid policies and regulations, as well as the changing climate of the member and provider communities.

In accordance with 42 CFR 438 Subpart E, the State will maintain a written strategy for assessing and improving the quality of services offered by MCOs including, but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries. MCOs must comply with the standards established by the State and must provide all information and reporting necessary for the State to carry out its obligations for the State quality strategy. MCOs are contractually required to ensure that the results of each external independent review are available to participating health care providers, members, and potential members of the organization, except that the results may not be made available in a manner that discloses the identity of any individual patient. Further, MCOs must establish stakeholder advisory boards that advise and provide input into: (a) service delivery; (b) quality of care; (c) member rights and responsibilities; (d) resolution of grievances and appeals; (e) operational issues; (f) program monitoring and evaluation; (g) member and provider education; and (h) priority issues identified by members. In accordance with 42 CFR 438 Subpart E, the State will regularly monitor and evaluate the MCOs' compliance with the standards established in the State's quality strategy and the MCOs' QM/QI program. The State is in the process of developing specific processes and timelines to share quality data with stake holders such as, agencies, waiver providers, members, families, other interested parties and the public. This will include strategies such as leveraging the Medical Assistance Advisory Council (MAAC).

The HCBS QIO completes review of HCBS enrolled providers on a three-to-five-year cycle. During the onsite review HCBS ensures personnel are trained in:
- Suspected child abuse and dependent adult abuse reporting
- Incident reporting
- Have mandatory reporter training
- Member support needs
- Rights restrictions
- Storage and administration of member medication

In addition, HCBS QIO reviews the centralized incident report file, appeals and grievances, and any allegations of abuse. During the review of service documentation, any incident identified in narrative which falls under the incident description in IAC Chapter 77 is required to have an incident report filed. The provider's tracking and trending of incident reports is also reviewed during the onsite review. Any areas the provider may be out of compliance results in the requirement of a corrective action plan. HCBS gives the provider 30 days to submit a time limited corrective action plan which will remediate the deficiency. 45 days after the corrective action plan has been accepted HCBS follows up and requires the agency to submit evidence that the corrective action plan was put into place.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- (●) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

As established in rule and reinforced through signed provider agreements, HCBS providers are required to permit Iowa Medicaid, its designee or other governmental entities acting in its official capacity to examine any documents or records to ascertain information that payments made for claims of services were properly reimbursed by the Medicaid program. The Iowa Medicaid Program Integrity and Compliance Bureau (PIC) conducts audits and investigation of all Fee-For-Service (FFS) claims submitted by all Medicaid Provider types including HCBS providers. Iowa Medicaid contracts with a program integrity vendor to support its program integrity and compliance operations. The Managed Care Plans (MCPs or MCOs) special Investigation Unit (SIU) conducts audits and investigation of all Encounter claims submitted by providers receiving Medicaid reimbursement through the managed care plans. Any credible allegation of fraud identified by the PIC or SIU unit is referred to the Department of Inspection and Appeals Medicaid Fraud and Control Unit (MFCU) for further investigation for fraud.

Should the State require a provider to perform a self-review, the prescribed methodology for review is determined on a case-by-case basis and is generally determined based on the nature and scope of the issue identified. The state compares the results of the MCO PI efforts to the results achieved in past years. However, MCO operations tend to rely more on prior authorization of services and pre-payment claims editing to control costs, and as such this type of comparison will not be straightforward and may not provide useful information. When the PIC vendor identifies an overpayment for FFS claims, a Preliminary Report of Tentative Overpayment (PROTO) letter is sent to the provider. The PROTO letter gives the provider an opportunity to ask for a re-evaluation and they may submit additional documentation at that time. After the re-evaluation is complete, the provider is sent a Findings and Order for Repayment (FOR) letter to notify them of any resulting overpayment. Both the PROTO letter and the FOR letter are reviewed and signed off by state PIC staff prior to mailing. The FOR letter also includes appeal rights to inform the provider that they may appeal through the State Fair Hearing process. When overpayments are recovered, claims adjustments are performed which automatically results in the FFP being returned to CMS. The OHCDS Medicaid audit is subject to the same standards and processes as outlined for FFS. The state's contracted MCOs are also responsible for safeguarding against, and investigating reports of, suspected fraud and abuse. MCOs are required to fully cooperate with the HHS PIC Unit by providing data and ongoing communication and collaboration. Per 42 CFR 438.608 and 42 CFR Part 455, MCOs must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The PI Plan must be updated annually and submitted to HHS for review and approval. The MCOs are also required to make referral to Iowa Medicaid and the MFCU for any suspected fraudulent activity by a provider. On a monthly basis, the MCO must submit an activity report to HHS, which outlines the MCO's PI-related activities and findings, progress in meeting goals and objectives, and recoupment totals. Each MCO is also required to meet in person with the Iowa Medicaid PIC Unit, the Iowa Medicaid Managed Care Oversight Bureau, and the MFCU on at least a quarterly basis to coordinate on open cases and review the MCO's program integrity efforts. Iowa's MCOs continuously conduct reviews/audits on providers in their networks. The degree to which these include HCBS providers varies over time depending on tips received and leads from data analytics.

The PIC bureau conducts audits of MCP payments made to network providers. Under section I.9 of the contract, any improper payments made to a provider by MCPs may be subject to oversight audit and overpayments identified may be subject to recovery by Iowa Medicaid.

I.9.01. Recovery of Overpayments from Contractor. The Agency or its Designee may audit Contractor's Provider Claims and recover from the Contractor the identified Provider Overpayments by following the procedures in this Section.

I.9.02. Notice. If the Agency identifies a Provider Overpayment owed to the Contractor, the Agency shall send notice to the Contractor identifying the Overpayment.

I.9.03. Payment. On or before the thirtieth (30th) day following the date of the notice, the Contractor shall either pay the Agency the amount identified as a Provider Overpayment or shall dispute the Overpayment in writing to the Program Integrity Director or other Agency representative designated by the Agency.

I.9.04. Payment Disputes. If the Contractor disputes the Overpayment, the Program Integrity Director or other Agency representative will consider the Contractor's dispute and shall notify the Contractor of its final decision on or before the thirtieth (30) day following the date the written dispute is received. The Agency has the sole discretion to uphold, overturn, or amend an identified Overpayment. If the Contractor disputes the Overpayment and the Agency's final decision identifies an Overpayment, the Contractor shall pay the Agency the identified Overpayment on or before the tenth (10th) business day following the final decision.

I.9.05. Extensions. If the Contractor makes a written request on or before the due date for the payment of the Overpayment, the Agency, through its Program Integrity Director or other Agency representative may, in its sole discretion, grant an

extension of time within which the Contractor must pay the Overpayment.

I.9.06. Contractor Recovery from Providers. Where the Agency has identified an Overpayment and the Contractor has been required to pay the amount of the Overpayment to the Agency, the Contractor shall recover the Overpayment from the Provider and may retain the Overpayment recovered.

I.9.07. Offsets. If the Contractor fails to repay an Overpayment identified under these procedures, the Agency may offset the amount of the Overpayment owed by the Contractor against any payments owing to Contractor under this Contract.

I.9.08. Agency-Identified Overpayments. If the Agency discovers and identifies an improper payment or overpayment after twenty-four (24) months from the date the claim was paid, the Agency will recover the identified Overpayment from the Contractor, unless the improper payment or overpayment was the result of an Agency error. The Contractor shall not recover Overpayments for which it did not discover or issue a, overpayment finding to the Provider. The Contractor may dispute the Agency's notice of findings in accordance with the Payment Integrity Audit process.

As part of the EQR process, the contractor performs onsite reviews of the MCOs that include processes that impact waiver providers and members. Reviews include credentialing files, critical processes such as service authorization validation, claims processing, training and care coordination.

The State reviews monthly, quarterly, annual reports and compliance plans to provide oversight on the MCO programs. Each MCO has meetings monthly with the State and the Medicaid Fraud Control Unit (MFCU) to review fraud waste and abuse referral information and provide any updates regarding open investigations. Monthly fraud waste and abuse referrals, audits/investigations, closed cases, overpayment letters, overpayments collected, among other numerical values are tracked and trended with the previous year's data on a dashboard updated monthly.

MCO oversight is conducted regularly to validate correct reporting. The PIC unit reviews of MCO claims to ensure providers are billing and rendering services appropriately. The PIC unit notifies the MCOs of any review findings for them to pursue further PI activities with the provider.

MCOs must also coordinate all PI efforts with Iowa Medicaid and Iowa's MFCU. MCOs must have in place a method to verify whether services reimbursed were furnished to members as billed by providers and must comply with 42 CFR Part 455 by suspending payments to a provider after HHS determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual/entity unless otherwise directed by HHS or law enforcement. MCOs shall comply with all requirements for provider disenrollment and termination as required by 42 CFR §455.

The Auditor of the State has the responsibility to conduct periodic independent audit of the waiver under the provisions of the Single Audit Act. All HCBS cost reports will be subject to desk review audit and, if necessary, a field audit. However, the department may require that an external accountant experienced with cost report preparation prepare the financial and statistical report or that a certified public accountant complete a review or examination of the financial and statistical report or cost allocation methodology.

Electronic visit verification (EVV) assists in validating the provision of services and monitoring the accuracy of payments for waiver services to providers. Iowa requires that MCOs have EVV information for all required personal care and home health care services. Iowa reviews aggregate EVV compliance reports to understand utilization trends and EVV compliance. Program integrity oversight of EVV claims data will be reviewed for accuracy and improper payments are identified and remedied as outlined undersection I.9 of the contract. There are currently no services delivered under the Children and Youth waiver that require EVV.

Iowa Medicaid currently does not require EVV for FFS. Iowa Medicaid will continually reassess FFS EVV implementation. Iowa accepts and calculates the FMAP reduction.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
FA-a1: Number and percent of FFS claims paid for services provided to waiver members for which there is a corresponding prior authorization. Numerator: Number of FFS claims paid for services provided to waiver members for which there is a corresponding prior authorization.; Denominator: Total number of reviewed paid claims

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☒ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☒ ***Other*** *Specify:*	☐ ***Annually***	☒ ***Stratified*** *Describe Group:*

Contracted Entity		IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
FA-a2: Number and percent of clean claims that are paid by the managed care

organizations within the timeframes specified in the contract. Numerator: number of clean claims that are paid by the managed care organization within the timeframes specified in the contract; Denominator: number of Managed Care provider claims.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
FA-a3: Number and percent of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for waiver services provided.
Numerator: Number of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for waiver services provided; Denominator: Number of paid claims

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

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

	Ongoing	*Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

FA-b1: Number and percent of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology. Numerator: # of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology; Denominator: # of capitation payments to the MCO's.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

The Program Integrity unit samples provider claims for quality. These claims are cross-walked with service documentation to determine error associated with coding and documentation. This data is reported on an adhoc basis. MCO claims data is compared to the contractual obligations for MCO timeliness of clean claim payments. Data is provided to the HCBS staff as well as to the Bureau of Managed Care and Oversight. MCO contractual definition of a clean claim: A claim that has no defect or impropriety (including any lack of required substantiating Documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

b. Methods for Remediation/Fixing Individual Problems

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

When the Program Integrity & Compliance Operations Unit (PICOU) discovers situations where providers have improperly billed for services or there is missing documentation to support billing of services, the PICOU communicates findings of overpayment and recoup the overpaid amount from the provider. If the findings do not result in an overpayment, the PICOU will notify the provider of no recoupment and provide education and/or technical assistance, if appropriate to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the PICOU may review an expanded sample of claims and make referral to Medicaid Fraud Control Unit (MFCU) if there are indicators of fraud. HHS may suspend payments to the provider pending the outcome of the investigation by MFCU.

The data and case information gathered from this process is stored in the Program Integrity tracking system.

If during the review of capitation payments HHS determines that a capitation payment was made in error, the Encounter claim is recouped or adjusted to correct the payment.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

441 Iowa Administrative Code (IAC) Chapter 79 sets forth the principles governing reimbursement of providers of medical and health services. Specifically, "The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member."

Services under this waiver are reimbursed based on a set fee schedule. This includes the services authorized under the Consumer Choices Option (CCO) Self-Direction Budgets. Providers are reimbursed at the set rate regardless of geographic location within the state. Iowa Medicaid sets the upper rate limit for those services as published on the HHS Iowa Medicaid Fee Schedule webpage. The Fee Schedules were last updated July 1, 2026, and are posted online https://hhs.iowa.gov/programs/welcome-iowa-medicaid/policies-rules-and-regulations/covered-services-rates-and-payments/fee-schedules.

For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by HHS Iowa Medicaid according to the Medicare reimbursement method described in section 1834(a) of the Social Security Act (42 U.S.C. 1395m), payment for durable medical equipment. Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent. Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost, plus 10 percent. For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality. Payment for used equipment shall not exceed 80 percent of the purchase allowance. No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies in accordance with 441 IAC Chapter 79.

Fee schedules are determined by HHS Iowa Medicaid with advice and consultation from the appropriate professional group at the time the fee schedule is developed. Individual service rate adjustments are made periodically to correct any rate inequity. The legislature can direct Iowa Medicaid to increase or decrease rates through a legislative mandate. There is no set cycle for the legislature to change rates. Iowa Medicaid will change the rates accordingly. All providers rates are subject to public comment any time there is a change in reimbursement methodology. Rate determination methods are set forth in IAC and subject to the State's Administrative Procedures Act, which requires a minimum twenty-day public comment period. How the State solicits public comments on rate determination methods can be found in Main, section 6-I. When the legislature appropriates increases for provider agency reimbursement rates the CCO rates for waiver services are increased by the same percentage.

During service plan development, the case manager shares with the member the rates of the providers, and the member can choose a provider based on their rates. When a service is authorized in a member's service plan, the providers receive a Notice of Decision, which indicates the participant's name, provider's name, service to be provided, the dates of service to be provided, units of service authorized, and reimbursement rate for the service.

HCBS reimbursement methodologies are reviewed every five years, at a minimum. When the department reviews reimbursement levels for adequacy; historical experience, current reimbursement levels, experiences in other states, and network adequacy are considered. The results of the benchmarking indicate whether the rates are adequate to maintain an ample provider network or if legislative appropriation is necessary to increase or align rates. HCBS reimbursement rates were last increased for dates of service beginning July 1, 2024.

HCBS Prevocational Services, Respite, and Supported Employment reimbursement rates were last increased for dates of service beginning August 1, 2025, all other services were last increased for dates of service beginning July 1, 2024.

Oversight of the rate determination process is conducted by Iowa Medicaid. The Iowa Medicaid Provider Cost Audit and Rate Setting unit, compiles the data needed to complete the rate calculations, prepares the report, performs the review of calculations and reports, and submits the report to Iowa Medicaid for review and approval. Iowa Medicaid budget analyst and actuary review the rate calculations to determine accuracy.

MCO capitation rate development methodologies are described in the §1915(b) waiver and associated materials. MCO rates are blended between fee-for-service and managed care capitated payments based on the anticipated percentage of unduplicated participants per delivery system.

The following services may be rendered via telehealth under this waiver: positive behavioral support and consultation, supported employment, and peer mentoring. When services are delivered via telehealth, reimbursement is the same as if the services were rendered in person.

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

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

For fee-for-service members, providers shall submit claims on a monthly basis for waiver services provided to each member served by the provider agency. Providers submit electronic claim forms. Electronic claims must utilize a HIPAA compliant software and shall be processed by the Iowa Medicaid Provider Services Unit.

Providers shall submit a claim form that accurately reflects the following: (1) the provider's approved NPI provider number and Medicaid legacy number for waiver enrollment; (2) the appropriate waiver service procedure code(s) and modifier(s) that corresponds to the waiver services authorized in the member's service plan; (3) the dates of service; and (4) the appropriate number of waiver service unit(s) and the service rate that corresponds to the service. The member's name and state Medicaid identification number is required on all claim forms.

Specific to the CCO program, the FMS is responsible to process and pay invoices for approved goods and services included in the members' CCO budgets, maintain documentation and monitor that payments are reflected in the member's CCO budget. All support employees that a CCO member hires must complete service documentation and timecards and submit them to the FMS to be paid for services. All other goods and services purchased that are listed in the member's CCO budget must be submitted to the FMS with a receipt or invoice in order for payment to be made.

Iowa Medicaid issues FFS provider payments weekly. The MMIS system edits ensure that payment will not be made for services that are not included in an approved service plan in IoWANS. Any change to IoWANS data generates a new authorization milestone for the case manager. The IoWANS process culminates in a final IoWANS milestone that verifies an approved service plan and approved service span has been entered into IoWANS. IoWANS data is updated daily into MMIS.

For MCO members, providers bill the managed care entity with whom a member is enrolled in accordance with the terms of the provider's contract with the MCO.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b)

how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The MMIS system includes edits to make sure that payments for claims are made only when a member is eligible for waiver services and when the services are included in the member's service plan. A member's eligibility for payment of waiver services on the date of service as verified by an authorized service plan in IoWANS. The billing validation method includes the date the service was provided, time of service provision, and the state ID of the member receiving the service. Several entities monitor the validity of claim payments: (1) case manager ensures that the services were provided by reviewing paid claims information made available to them for each of their members through IoWANS; (2) the Iowa Medicaid Program Integrity Unit performs a variety of reviews by either random sample or outlier algorithms.

The MMIS system includes system edits to ensure that prior to issuing a capitation payment to an MCO the member is eligible for the waiver program and is enrolled with the MCO. MCOs must implement system edits to ensure that claim payments are made only when the member is eligible for waiver services on the date of service. The MCOs are required to develop and maintain an electronic community-based case management system that captures and tracks service delivery against authorized services and providers. The State monitors MCO compliance and system capability through pre-implementation readiness reviews and ongoing monitoring such as a review of sampled payments to ensure that services were provided and were included in the member's approved plan of care. The MCOs are also responsible for program integrity functions with HHS review and oversight.

When inappropriate billings are discovered (i.e.: overpayments determined) the provider is notified in writing of the overpayment determination. Providers are given the opportunity to review the overpayment and provide additional information to support the claims for payment. Based on the final notice of overpayment, the provider either submits a refund check to Iowa Medicaid or the overpayment is set as a credit balance within the MMIS. Future claim payments are then used to reduce and eliminate the credit balance. Providers have the right to request a State Fair Hearing when they dispute a finalized overpayment request.

Meanwhile, the overpayments are recorded and reported to the state data warehouse using an end-of-month A/R reporting process. Any overpayments determined during a particular month are reported for that month. Any recoveries of these overpayments are similarly recorded and reported to the state data warehouse using the same end-of-month A/R process and for the month in which the recoveries were made. The dates on which the respective overpayments occurred and the recoveries made are part of this month-end A/R reporting. Bureau of Fiscal Management staff then extracts this reporting from the data warehouse to construct the CMS-64 report, the official accounting report submitted by the Department to CMS (the state's claiming mechanism for FFP). The CMS-64 report shows CMS what Iowa's net expenditures are for the quarter and is used to determine a final claim of federal funds. The federal-dollar share of any overpayments not recovered within 12 months of the payment itself must be returned to CMS and this is accomplished through the CMS-64 report as well.

For the Consumer Choices Option, the FMS is responsible to provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused and promptly report and return unused funds to Iowa Medicaid within 60 days of identification. The FMS is responsible for monitoring timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years and provide to the department an annual independent audit of the financial management service.

As described in I-1, EVV is currently only applicable to personal care services and home health care services delivered under managed care. The EVV system assists the managed care plans in validating the provision of services and monitoring the accuracy of payments for waiver services to providers. The EVV vendor reviews all service documentation entries prior to submitting the claims for payment to the MCOs. Iowa Medicaid reviews aggregate EVV compliance reports to understand utilization trends and EVV compliance.

Prevention of member coercion:
Case managers are responsible for facilitating and coordinating the interdisciplinary team for each member and ensuring the unencumbered right of the member to choose their services and the provider for each service that will meet the member's needs.

Iowa Medicaid HCBS QIO observes a random sample of interdisciplinary team (IDT) meetings conducted by case managers. This allows the HCBS QIO to note any member coercion in choice of providers. HCBS QIO staff then requests the final signed, approved service plan to ensure that the plan includes the services, units and providers chosen by the member. Any changes and omissions require follow-up by the HCBS QIO for resolution by the FFS case manager or

MCO.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Providers shall submit a claim form that accurately reflects the following: (1) the provider's approved NPI provider number and Medicaid legacy number for waiver enrollment; (2) the appropriate waiver service procedure code(s) and modifier(s) that corresponds to the waiver services authorized in the member's service plan; (3) the dates of service; and (4) the appropriate number of waiver service unit(s) and the service rate that corresponds to the service. The member's name and state Medicaid identification number is required on all claim forms.

Iowa Medicaid issues provider payments weekly. The MMIS system edits ensure that payment will not be made for services that are not included in an approved IoWANS service plan. Any change to IoWANS data generates a new authorization milestone for the case manager. The IoWANS process culminates in a final IoWANS milestone that verifies an approved service plan has been entered into IoWANS. IoWANS data is updated daily into MMIS.

For payments made by Iowa Medicaid: Providers are informed about the process for billing Medicaid directly through annual provider training, Iowa Medicaid informational bulletins, and the Iowa Medicaid provider manual. When a provider has been enrolled as a Medicaid provider, Iowa Medicaid Provider Services mails the provider an enrollment packet that includes how the provider can bill Medicaid directly. The Provider billing manual is also available on the Iowa HHS website at: https://hhs.iowa.gov/about/policy-manuals/medicaid-provider

Capitation payments to MCOs are made by the MMIS. The MMIS has recipient eligibility and MCO assignment information. When a recipient is enrolled in an MCO, this is reflected on his/her eligibility file and monthly payment flows from the MMIS to the MCO via an 837 transaction. A monthly payment to the MCO on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

The claim details submitted for payment is reviewed and reconciled by Iowa Medicaid and supporting claim detail is maintained. Payment for these services is recorded in the state's accounting system. The accounting records and claim detail provide the audit trail for these payments.

For CCO enrollees the Financial Management Service (FMS) provider receives Medicaid funds on behalf of the member based on the member's approved monthly budget. The FMS is the employer of record and performs the following services:
• Receive Medicaid funds in an electronic transfer.
• Process and pay invoices for approved goods and services included in the individual budget.
• Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
• 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.
• Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
• Preparing and issuing employee payroll checks.
• Preparing and disbursing IRS Forms W-2 and W-3 annually.
• Processing federal advance earned income tax credit for eligible employees.
• Refunding over-collected FICA, when appropriate.
• Refunding over-collected FUTA, when appropriate
• Assist the member in completing required federal, state, and local tax and insurance forms.
• Establish and manage documents and files for the member and the member's employees.
• Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For payments made by Iowa Medicaid:
Providers are informed about the process for billing Medicaid directly through annual provider training, Iowa Medicaid informational bulletins, and the Iowa Medicaid provider manual.

When a provider has been enrolled as a Medicaid provider, Iowa Medicaid Provider Services mails the provider an enrollment packet that includes how the provider can bill Medicaid directly. The provider billing manual is also available on the Iowa HHS website at: https://hhs.iowa.gov/about/policy-manuals/medicaid-provider

Members' employees through the CCO program are issued instructions on billing through the FMS. MMIS will not allow payment for services authorized through CCO.

Iowa Medicaid exercises oversight of the fiscal agent through both the IoWANS system and through our Core Unit.

Payment for services by the FMS include:
-Prevocational Services
-Respite
-Supported Employment
-Independent Support Broker
-Individual Directed Goods and Services
-Assistive Devices
-Family and Community Support
-Home and Vehicle Modifications
-Home-Delivered Meals
-Medical Day Care for Children
-Personal Emergency Response System
-Transportation

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

(13) Establish a customer services complaint reporting system.
(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
(15) Develop a business continuity plan in the case of emergencies and natural disasters.
(16) Provide to the department an annual independent audit of the financial management service.
(17) Assist in implementing the state's quality management strategy related to the financial management service."

This information is included in the amendment in Appendix E-1-a.

For payments made by the MCO:
For MCO enrollees, for the self-direction option of the waivers, payments will be made to a financial management service, which will be designated by the state as an organized healthcare delivery system to make payments to the entities providing support and goods for members that self-direct. The financial management service must meet provider qualifications established by the state and pass a readiness review approved by the state and be enrolled as a Medicaid provider with the state. The state will also oversee the operations of the financial management service by completing periodical audits.

Iowa Medicaid exercises oversight of the fiscal agent through both the IoWANS system and through our Core Unit. The Iowa Medicaid Core unit performs a myriad of functions for the Iowa Medicaid including, but not limited to, processing and paying claims, handling mail, and reporting. This unit also maintains and updates the automated eligibility reporting system known as Eligibility and Verification information System (ELVS). Iowa Medicaid has regularly scheduled meetings with Core to review the thresholds of the performance measures they are required to meet to assure quality.

☒ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

N/A

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The Woodward State Resource Center is the only state agency that provides community-based services including Home and Vehicle Modification, Respite, and Transportation.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ○ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ◉ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

For fee-for-service members, providers receive and retain 100% of the amount claimed to CMS for waiver services. The payment to capitated MCOs is reduced by a performance withhold amount as outlined in the contracts between HHS and the MCOs. The MCOs are eligible to receive some or all of the withheld funds based on the MCO's performance in the areas outlined in the contract between HHS and the MCOs.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

Enrolled Medicaid Home and Vehicle providers may choose to subcontract to non enrolled businesses for the provision of Home and Vehicle Modifications and Assistive Devices. The authorization for the service and the Medicaid payment for the authorized service is made to the enrolled Medicaid provider that would then forward payment to the subcontractor in accordance with their contract

Enrolled Medicaid Home and Vehicle providers who sub-contract with non-enrolled businesses for the provision of home and vehicle modifications or assistive devices must assure that the subcontractor is contractually obligated to abide by the rules and standards applicable to the services. The member's case manager is responsible for ensuring that the services were provided in accordance with the member's service plan and in accordance with rules and standards for the applicable service.

Any subcontractor who is qualified to enroll with Iowa Medicaid is encouraged to do so. No provider is denied Medicaid enrollment for those services that they are qualified to provide. Waiver providers are not required to contract with an OHCDS in order to furnish services to members.

When a member has been assessed to have a need for any waiver service, the member is offered the full choice of available providers. The member has the right to choose from the available providers; the list of providers is available through the case manager or community-based case manager, and is also available through Iowa Medicaid and MCO websites. In accordance with the Iowa Administrative Code, all subcontractors must meet the same criteria guidelines as enrolled providers and the contracting enrolled provider must confirm that all criteria are met.

The Financial Management Services (FMS) entities are designated as an OHCDS as long as they meet provider qualifications as specified in C-3. Iowa Medicaid executes a provider agreement with the FMS providers and MCOs contract with an Iowa Medicaid enrolled Financial Management Services solution. Members have free choice of providers. Members are given this information during their service plan development. The FMS reviews and certifies that established provider qualifications have been met for each individual or vendor receiving Medicaid reimbursement.

Employer/employee agreements and timesheets document the services provided if waiver members elect to hire and manage their own workers. The purchase of goods and services is documented through receipts and/or invoices. For each purchase for fee-for-service members, Medicaid funding from the MMIS to the provider of the service is accurately and appropriately tracked through the use of Iowa's IoWANS. Financial oversight and monitoring of the OHCDS is administered by the Iowa Medicaid through an initial readiness review to determine capacity to perform the waiver services and throughout the year using a reporting system, random case file studies and the regular Medicaid audit process. MCOs are contractually required to develop a system to track all OHCDS Financial Management Services, which is subject to HHS review and approval. Further, the MCOs maintain financial oversight and monitoring with ongoing review and authority retained by HHS.

The OHCDS Medicaid audit is subject to the same standards and processes as outlined for FFS. The state's contracted MCOs are also responsible for safeguarding against, and investigating reports of, suspected fraud and abuse. MCOs are required to fully cooperate with the HHS PI Unit by providing data and ongoing communication and collaboration. Per 42 CFR 438.608 and 42 CFR Part 455, MCOs must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The PI Plan must be updated annually and submitted to HHS for review and approval. The MCOs are also required to make referral to Iowa Medicaid and the MFCU for any suspected fraudulent activity by a provider. On a monthly basis, the MCO must submit an activity report to HHS, which outlines the MCO's PI-related activities and findings, progress in meeting goals and objectives, and recoupment totals. Each MCO is also required to meet in person with the Iowa Medicaid PI Unit, the Iowa Medicaid Managed Care Oversight Bureau, and the MFCU on at least a quarterly basis to coordinate on open cases and review the MCO's program integrity efforts. Iowa's MCOs continuously conduct reviews/audits on providers in their networks. The degree to which these include HCBS providers varies over time depending on tips received and leads from data analytics.

A provider must enroll with Medicaid prior to being eligible to enroll with a managed care organization. They are not required to contract with a MCO as this is a provider/MCO contractual arrangement.

However, Medicaid will notify the MCO of all providers eligible to provide services.

Each MCO has different systems that maintain authorized service plans. Many of the services are prior authorized and claims are adjudicated against the authorizations.

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ◉ ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***
- ☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the

Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes*

or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

Check each that applies:

- ☐ ***Health care-related taxes or fees***
- ☐ ***Provider-related donations***
- ☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital, Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	10964.28	13972.36	24936.64	31119.29	62937.46	94056.75	69120.11
2	11454.92	14597.02	26051.94	32510.52	65751.17	98261.69	72209.75
3	11967.43	15249.60	27217.03	33963.96	68690.68	102654.64	75437.61
4	12502.27	15931.35	28433.62	35482.36	71761.60	107243.96	78810.34
5	13061.15	16643.59	29704.74	37068.66	74969.80	112038.46	82333.72

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care:	Level of Care:	Level of Care:
		Hospital	Nursing Facility	ICF/IID

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care: Hospital	Level of Care: Nursing Facility	Level of Care: ICF/IID
Year 1	3408	1761	1096	551
Year 2	3408	1761	1096	551
Year 3	3408	1761	1096	551
Year 4	3408	1761	1096	551
Year 5	3408	1761	1096	551

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay (ALOS) is expected to remain the same throughout the five years of the waiver. The ALOS days were based on historical data supporting the Children and Youth waiver for the period from July 2023 – June 2024.

Unduplicated participants were trended in the current approved waiver based on historical participant levels. While unduplicated participants are based on approved maximum waiver caps, the total unduplicated number of participants remains even over the five years of the current renewal base. The number of unduplicated participants reflects the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.

Limitations on the Number of Participants Served at any Point in Time remain constant each year based on historical growth, average monthly costs per recipient on the waiver, and maximum waiver caps approved by CMS.

Both the unduplicated number of participants and the participant limit are based on CMS guidance.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates are as follows:

Factor D, (1915(c) HCBS Services), is based on historical fee-for-service and Iowa Health Link managed care encounter data from state fiscal year (SFY) 24, (July 1, 2023, to June 30, 2024). This data was limited to individuals whose age was between 0-21 years old and who were previously enrolled in the AIDS/HIV, Children's Mental Health, Health and Disability, and Physical Disability HCBS waivers. As part of this data evaluation, the number of unique users and member months enrolled in the above listed 1915(c) HCBS waivers were retained and used to establish comparable Factor G and G'. This is described in the response to Factors G and G'.

Develop J-2-d for Waiver Year 1 - - (October 1, 2026, to June 30, 2027)
• Users: The Users for each 1915(c) service are based on historical utilization applied to the state's estimated users in J-2-a for Waiver Year 1.
• Average Units Per User: The average units per user for each service is based on historical utilization applied to estimated users in J-2 for Waiver Year 1. New 1915(c) services in the Children and Youth service array were estimated. These estimates were informed by evaluating existing 1915(c) services being consolidated or terminated as part of the Children and Youth service package.
• Average Cost per Unit: The average unit cost reflected is based on the state-established reimbursement for each service outlined in Appendix J-2.

Projection to Develop J-2 for Waiver Years 2-5
Waiver Year 1 estimates were trended to Waiver Years 2 through 5 based on an average annual trend factor of 4.5%. Trends were developed on a statewide annualized basis, primarily using IA Health Link specific experience from SFY24 and emerging SFY25 through December 2024, and represent the annualized trend for the waiver Category of Service (COS) for the waiver Categories of Aid (COA).

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates to Develop Factor D' for Waiver Year 1 (October 1, 2026, to June 30, 2027)
Factor D' (non-HCBS service expenditures), is based on historical fee-for-service and IA Health Link managed care encounter data from state fiscal year (SFY) 24, (July 1, 2023, to June 30, 2024). This data was limited to individuals whose age was between 0 and 21 years old and who were previously enrolled in the AIDS/HIV (AIDS/HIV), Children's Mental Health (CMH), Health and Disability (HD), and Physical Disability (PD) 1915(c) HCBS waivers.

The Factor D' service costs were developed using historical FFS and IA Health Link Capitated rates. For FFS, these data were aggregated based on ages 0 and 21 years old. Data from the IA Health Link program was evaluated for individuals whose ages were 0 and 21 years old and compared to aggregated IA Health Link capitation rates for HCBS waiver populations to establish an age-based factor. The age-based factor was applied to the total projected SFY26 capitation rates and the medical services component, and trended to Waiver Year 1. The average annual trend factor, based on the historical Health Link specific experience, was 4.5%.

Projection to Develop J-2 for Waiver Years 2-5
Waiver Year 1 estimates were trended to Waiver Years 2 through 5 based on an average annual trend factor of 4.5%.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates to Develop Factor G for Waiver Year 1 (October 1, 2026, to June 30, 2027)
Factor G (Institutional facility cost) is based on IA Health Link managed care encounter data from state fiscal year 24 (July 1, 2023, to June 30, 2024). This data was limited to individuals between 0 and 21 years old who were receiving services through institutions. The institutions utilized for Factor G include: Custodial Care Nursing Facility, Skilled Nursing Facility, Psychiatric Medical Institutions for Children (PMIC), and Residential Care Facility (RCF).

The institutional costs for each facility type (e.g., PMIC) were evaluated for individuals whose ages were 0-21 years old and compared to aggregated IA Health Link capitation rates for institutional populations to establish an age-based factor. This age factor was applied to the projected SFY26 medical component of the IA Health Link institutional rate cohorts to establish the projected SFY26 Factor G cost for 0–21 year-olds.

The Children and Youth waiver consolidates existing 1915(c) HCBS waivers. Factor G estimates incorporated the enrollment distribution from the 1915(c) population and their institutional equivalent(s). The institutional equivalents were aggregated to establish a per capita amount and then weighted on the distribution of individuals from the HCBS waiver to establish the Factor G for the Children and Youth HCBS population. The institutional equivalents that correlate to the 1915(c) HCBS populations (AIDS/HIV, CMH, HD, and PD) are custodial care nursing facility, skilled nursing facility, PMIC, and RCF.

The weighted average Factor G was trended using an annual trend factor of 4.5%. The average annual trend factor, was based on the historical Health Link specific experience.

Projection to Develop Factor G for Waiver Years 2-5
Waiver Year 1 estimates were trended to Waiver Years 2 through 5 based on an average annual trend factor of 4.5%.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates to Develop Factor G’ for Waiver Year 1 (October 1, 2026, to June 30, 2027)
Factor G’ (non-institution service expenditures) are based on historical IA Health Link managed care encounter data from state fiscal year (SFY) 24, (July 1, 2023, to June 30, 2024). The institutions utilized for Factor G' include: custodial care nursing facility -- skilled nursing facility -- psychiatric medical institutions for children (PMIC) -- and residential care facility (RCF).

The institution service costs for individuals between 0 and 21 years old were aggregated and compared to the total cost (institution + state plan services) to establish an age factor. This age factor was applied to the projected SFY26 medical component of the IA Health Link institutional rate cohorts to establish the projected SFY26 Factor G’ cost.

Since the Children and Youth waiver consolidates existing 1915(c) HCBS waivers, Factor G’ estimates used the enrollment distribution of the 1915(c) population and their institutional equivalent(s). The Factor G’ equivalents that correlate to the remaining HCBS populations (AIDS/HIV, CMH, HD, and PD) are custodial care nursing facility, skilled nursing facility, PMIC, and RCF. These Factor G’ equivalents were aggregated to establish a per capita amount and then weighted on the distribution of individuals from the HCBS waiver to establish the Factor G’ for the Children and Youth HCBS population.

The weighted average Factor G' was trended using an annual trend factor of 4.5%. The average annual trend factor was based on the historical Health Link specific experience.

Projection to Develop Factor G' for Waiver Years 2-5
Waiver Year 1 estimates were trended to Waiver Years 2 through 5 based on an average annual trend factor of 4.5%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.*

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

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:							**12962.60**
Prevocational Services	☒	hour	15	66.00	11.24	**11127.60**	
Prevocational Career Exploration	☒	hour	1	9.00	43.00	**387.00**	
Prevocational Services, FFS	☐	hour	2	62.50	11.24	**1405.00**	
Prevocational Career Exploration, FFS	☐	hour	1	1.00	43.00	**43.00**	
Respite Total:							**21190280.30**
Respite (home health agency; basic individual)	☒	15 minutes	3059	824.74	5.43	**13699236.55**	
Respite (home health agency; specialized)	☒	15 minutes	167	246.38	13.77	**566572.98**	
Respite (home care agency; basic group)	☒	15 minutes	3059	307.96	4.35	**4097915.93**	
Respite (hospital or NF)	☒	15 minutes	30	95.33	11.02	**31516.10**	
Respite (resident camp overnight)	☒	15 minutes	176	428.20	3.97	**299191.90**	
Respite (group day camp)	☒	15 minutes	155	197.35	3.97	**121439.32**	
Respite (home health agency; basic individual), FFS	☐	15 minutes	349	912.24	5.43	**1728758.66**	

GRAND TOTAL: **37366262.79**

Total: Services included in capitation: 33184978.33

Total: Services not included in capitation: 4181284.46

Total Estimated Unduplicated Participants: **3408**

Factor D (Divide total by number of participants): **10964.28**

Services included in capitation: 9737.38

Services not included in capitation: 1226.90

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite (home health agency; specialized), FFS	☐	15 minutes	22	236.00	13.77	71493.84	
Respite (home care agency; basic group), FFS	☐	15 minutes	349	340.60	4.35	517081.89	
Respite (hospital or NF), FFS	☐	15 minutes	5	72.20	11.02	3978.22	
Respite (resident camp overnight), FFS	☐	15 minutes	23	413.61	3.97	37766.73	
Respite (group day camp), FFS	☐	15 minutes	20	193.05	3.97	15328.17	
Supported Employment Total:							725522.05
Supported employment (small group) - Tier 1	☒	15 minutes	50	257.22	3.68	47328.48	
Supported employment (small group) - Tier 2	☒	15 minutes	10	318.10	2.30	7316.30	
Supported Employment (long term job coaching) - Hourly	☒	hour	7	109.14	26.85	20512.86	
Supported Employment (long term job coaching) - Tier 1	☒	hour	23	1.91	87.72	3853.54	
Supported Employment (long term job coaching) - Tier 2	☒	hour	81	3.01	468.69	114271.31	
Supported Employment (long term job coaching) - Tier 3	☒	hour	49	3.00	936.08	137603.76	
Supported Employment (long term job coaching) - Tier 4	☒	hour	30	1.97	1463.69	86504.08	
Supported Employment (long term job coaching) - Tier 5	☒	hour	52	67.77	58.54	206297.30	

GRAND TOTAL: 37366262.79

Total: Services included in capitation: 33184978.33

Total: Services not included in capitation: 4181284.46

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 10964.28

Services included in capitation: 9737.38

Services not included in capitation: 1226.90

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment (individual employment)	☒	hour	32	7.78	85.73	21343.34	
Supported employment (small group) - Tier 1, FFS	☐	15 minutes	7	233.00	3.68	6002.08	
Supported employment (small group) - Tier 2, FFS	☐	15 minutes	2	201.00	2.30	924.60	
Supported Employment (long term job coaching) - Hourly, FFS	☐	hour	1	96.00	26.85	2577.60	
Supported Employment (long term job coaching) - Tier 1, FFS	☐	hour	3	2.00	87.72	526.32	
Supported Employment (long term job coaching) - Tier 2, FFS	☐	hour	11	2.82	468.69	14538.76	
Supported Employment (long term job coaching) - Tier 3, FFS	☐	hour	7	2.57	936.08	16840.08	
Supported Employment (long term job coaching) - Tier 4, FFS	☐	hour	3	2.33	1463.69	10231.19	
Supported Employment (long term job coaching) - Tier 5, FFS	☐	hour	7	63.71	58.54	26107.08	
Supported Employment (individual employment), FFS	☐	hour	5	6.40	85.73	2743.36	
Financial Management Services Total:							809184.00
Financial Management Services	☒	fee	946	10.12	75.00	718014.00	
Financial Management Services, FFS	☐	fee	120	10.13	75.00	91170.00	
Independent							202142.25

GRAND TOTAL: 37366262.79

Total: Services included in capitation: 33184978.33

Total: Services not included in capitation: 4181284.46

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 10964.28

Services included in capitation: 9737.38

Services not included in capitation: 1226.90

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Broker Total:							
Independent Support Broker	☒	fee	237	10.09	75.00	**179349.75**	
Independent Support Broker, FFS	☐	fee	30	10.13	75.00	**22792.50**	
Individual Directed Goods and Services Total:							**9882099.58**
CCO goods and services; non-standard items or services, therapies; memberships	☒	service	946	205.20	42.68	**8285007.46**	
CCO goods and services; other savings - ongoing savings	☒	service	5	4.80	48.89	**1173.36**	
CCO workman's comp	☒	service	931	1.01	520.55	**489478.37**	
CCO goods and services; non-standard items or services, therapies; memberships, FFS	☐	service	120	204.06	42.67	**1044868.82**	
CCO goods and services; other savings - ongoing savings, FFS	☐	service	1	3.00	48.89	**146.67**	
CCO workman's comp, FFS	☐	service	118	1.00	520.55	**61424.90**	
Assistive Devices Total:							**43258.75**
Assistive devices per item; personal care item; adaptive device and therapeutic resources	☒	item	3	0.67	125.00	**251.25**	
Assistive Devices	☒	item	306	1.01	125.00	**38632.50**	
Assistive devices per item; personal care item; adaptive device and therapeutic resources, FFS	☐	item	0	0.00	0.01	**0.00**	

GRAND TOTAL: **37366262.79**

Total: Services included in capitation: 33184978.33

Total: Services not included in capitation: 4181284.46

Total Estimated Unduplicated Participants: **3408**

Factor D (Divide total by number of participants): **10964.28**

Services included in capitation: 9737.38

Services not included in capitation: 1226.90

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Devices, FFS	☐	item	35	1.00	125.00	4375.00	
Community Transition Services Total:							516090.00
Community Transition Services	☒	person	306	1.01	1500.00	463590.00	
Community Transition Services, FFS	☐	person	35	1.00	1500.00	52500.00	
Family and Community Support Total:							482005.87
Family and Community Support	☒	15 minutes	815	50.35	10.43	427997.66	
Family and Community Support, FFS	☐	15 minutes	104	49.79	10.43	54008.21	
Home and Vehicle Modifications Total:							579382.75
Environmental modifications and adaptive devices (Home Mod)	☒	item	45	1.00	7154.64	321958.80	
Environmental mod and adaptive devices (specialized supply)	☒	item	6	2.33	7154.64	100021.87	
Home and vehicle modification (vehicle only)	☒	item	12	1.00	7154.64	85855.68	
Environmental modifications and adaptive devices (Home Mod), FFS	☐	item	6	1.00	7154.64	42927.84	
Environmental mod and adaptive devices (specialized supply), FFS	☐	item	1	2.00	7154.64	14309.28	
Home and vehicle modification (vehicle only), FFS	☐	item	2	1.00	7154.64	14309.28	
Home-Delivered Meals Total:							1499378.04
Home delivered meals - morning	☒					107113.38	

GRAND TOTAL: 37366262.79

Total: Services included in capitation: 33184978.33

Total: Services not included in capitation: 4181284.46

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 10964.28

Services included in capitation: 9737.38

Services not included in capitation: 1226.90

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		meal	249	47.22	9.11		
Home delivered meals - supplemental meal	☒	meal	243	40.24	5.72	55931.99	
Home Delivered Meals; noon	☒	meal	1324	53.55	9.00	638101.80	
Home delivered meals - evening	☒	meal	1089	53.56	9.08	529607.71	
Home delivered meals - morning, FFS	☐	meal	33	45.09	9.11	13555.41	
Home delivered meals - supplemental meal, FFS	☐	meal	32	38.63	5.72	7070.84	
Home Delivered Meals; noon, FFS	☐	meal	169	53.17	9.00	80871.57	
Home delivered meals - evening, FFS	☐	meal	138	53.57	9.08	67125.35	
Medical Day Care for Children Total:							246022.16
Medical Day Care for Children	☒	15 minutes	24	918.13	10.02	220791.90	
Medical Day Care for Children, FFS	☐	15 minutes	3	839.33	10.02	25230.26	
Peer Mentoring Total:							34624.75
Peer Mentoring	☒	15 minutes	50	49.72	12.50	31075.00	
Peer Mentoring, FFS	☐	15 minutes	6	47.33	12.50	3549.75	
Personal Emergency Response System or Portable Locator System Total:							111073.16
Personal emergency response/locator (initial install fee)	☒	installation	8	1.00	51.82	414.56	
Personal emergency response/locator (monthly fee)	☒	month	792	3.03	40.94	98246.17	
Personal emergency response/locator	☐	installation	2	0.50	51.82	51.82	

GRAND TOTAL: 37366262.79

Total: Services included in capitation: 33184978.33

Total: Services not included in capitation: 4181284.46

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 10964.28

Services included in capitation: 9737.38

Services not included in capitation: 1226.90

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(initial install fee), FFS							
Personal emergency response/locator (monthly fee), FFS	☐	month	102	2.96	40.94	**12360.60**	
Positive Behavioral Support and Consultation Total:							**374399.94**
Positive Behavioral Support	☒	15 minutes	306	48.50	22.64	**336000.24**	
Positive Behavioral Support, FFS	☐	15 minutes	35	48.46	22.64	**38399.70**	
Transportation Total:							**657836.58**
Transportation; non-emergent wheelchair van; individual; per trip	☒	trip	22	16.73	54.83	**20180.73**	
Transportation; individual (per mile)	☒	mile	1147	63.39	3.11	**226122.91**	
Transportation; one way; individual	☒	1-way trip	323	32.58	32.00	**336746.88**	
Transportation; one way; group	☒	1-way trip	1	35.00	25.60	**896.00**	
Transportation; non-emergent wheelchair van; individual; per trip, FFS	☐	trip	5	9.00	54.83	**2467.35**	
Transportation; individual (per mile), FFS	☐	mile	148	62.28	3.11	**28666.24**	
Transportation; one way; individual, FFS	☐	1-way trip	43	30.98	32.00	**42628.48**	
Transportation; one way; group, FFS	☐	1-way trip	1	5.00	25.60	**128.00**	

GRAND TOTAL: **37366262.79**

Total: Services included in capitation: 33184978.33

Total: Services not included in capitation: 4181284.46

Total Estimated Unduplicated Participants: **3408**

Factor D (Divide total by number of participants): **10964.28**

Services included in capitation: 9737.38

Services not included in capitation: 1226.90

Average Length of Stay on the Waiver: 365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units*

Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:							**13524.04**
Prevocational Services	☒	hour	15	68.93	11.24	**11621.60**	
Prevocational Career Exploration	☒	hour	1	9.00	43.00	**387.00**	
Prevocational Services, FFS	☐	hour	2	65.50	11.24	**1472.44**	
Prevocational Career Exploration, FFS	☐	hour	1	1.00	43.00	**43.00**	
Respite Total:							**22137617.19**
Respite (home health agency; basic individual)	☒	15 minutes	3059	861.61	5.43	**14311660.90**	
Respite (home health agency; specialized)	☒	15 minutes	167	257.39	13.77	**591891.47**	
Respite (home care agency; basic group)	☒	15 minutes	3059	321.73	4.35	**4281148.50**	
Respite (hospital or NF)	☒	15 minutes	30	99.60	11.02	**32927.76**	
Respite (resident camp overnight)	☒	15 minutes	176	447.34	3.97	**312565.40**	
Respite (group day camp)	☒	15 minutes	155	206.17	3.97	**126866.71**	
Respite (home health agency; basic individual), FFS	☐	15 minutes	349	953.02	5.43	**1806039.61**	
Respite (home health agency; specialized), FFS	☐	15 minutes	22	246.55	13.77	**74689.86**	
Respite (home care agency; basic group), FFS	☐	15 minutes	349	355.83	4.35	**540203.31**	
Respite (hospital or	☐	15 minutes				**4154.54**	

GRAND TOTAL: ***39038381.05***

Total: Services included in capitation: *34673301.41*

Total: Services not included in capitation: *4365079.64*

Total Estimated Unduplicated Participants: ***3408***

Factor D (Divide total by number of participants): ***11454.92***

Services included in capitation: *10174.09*

Services not included in capitation: *1280.83*

Average Length of Stay on the Waiver: 366

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
NF), FFS			5	75.40	11.02		
Respite (resident camp overnight), FFS	☐	15 minutes	23	432.09	3.97	39454.14	
Respite (group day camp), FFS	☐	15 minutes	20	201.70	3.97	16014.98	
Supported Employment Total:							758457.91
Supported employment (small group) - Tier 1	☒	15 minutes	50	268.72	3.68	49444.48	
Supported employment (small group) - Tier 2	☒	15 minutes	10	332.30	2.30	7642.90	
Supported Employment (long term job coaching) - Hourly	☒	hour	7	114.00	26.85	21426.30	
Supported Employment (long term job coaching) - Tier 1	☒	hour	23	2.00	87.72	4035.12	
Supported Employment (long term job coaching) - Tier 2	☒	hour	81	3.15	468.69	119586.25	
Supported Employment (long term job coaching) - Tier 3	☒	hour	49	3.14	936.08	144025.27	
Supported Employment (long term job coaching) - Tier 4	☒	hour	30	2.07	1463.69	90895.15	
Supported Employment (long term job coaching) - Tier 5	☒	hour	52	70.81	58.54	215551.30	
Supported Employment (individual employment)	☒	hour	32	8.13	85.73	22303.52	
Supported employment (small group) - Tier 1, FFS	☐	15 minutes	7	243.43	3.68	6270.76	
Supported	☐					966.00	

GRAND TOTAL: 39038381.05

Total: Services included in capitation: 34673301.41

Total: Services not included in capitation: 4365079.64

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 11454.92

Services included in capitation: 10174.09

Services not included in capitation: 1280.83

Average Length of Stay on the Waiver: 366

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
employment (small group) - Tier 2, FFS		15 minutes	2	210.00	2.30		
Supported Employment (long term job coaching) - Hourly, FFS	☐	hour	1	100.00	26.85	**2685.00**	
Supported Employment (long term job coaching) - Tier 1, FFS	☐	hour	3	2.00	87.72	**526.32**	
Supported Employment (long term job coaching) - Tier 2, FFS	☐	hour	11	2.91	468.69	**15002.77**	
Supported Employment (long term job coaching) - Tier 3, FFS	☐	hour	7	2.71	936.08	**17757.44**	
Supported Employment (long term job coaching) - Tier 4, FFS	☐	hour	3	2.33	1463.69	**10231.19**	
Supported Employment (long term job coaching) - Tier 5, FFS	☐	hour	7	66.57	58.54	**27279.05**	
Supported Employment (individual employment), FFS	☐	hour	5	6.60	85.73	**2829.09**	
Financial Management Services Total:							**845161.50**
Financial Management Services	☒	fee	946	10.57	75.00	**749941.50**	
Financial Management Services, FFS	☐	fee	120	10.58	75.00	**95220.00**	
Independent Support Broker Total:							**211198.50**
Independent Support Broker	☒	fee	237	10.54	75.00	**187348.50**	
Independent Support Broker, FFS	☐	fee	30	10.60	75.00	**23850.00**	
Individual Directed							**10320930.11**

GRAND TOTAL: **39038381.05**

Total: Services included in capitation: 34673301.41

Total: Services not included in capitation: 4365079.64

Total Estimated Unduplicated Participants: **3408**

Factor D (Divide total by number of participants): **11454.92**

Services included in capitation: 10174.09

Services not included in capitation: 1280.83

Average Length of Stay on the Waiver: 366

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goods and Services Total:							
CCO goods and services; non-standard items or services, therapies; memberships	☒	service	946	214.37	42.68	**8655248.77**	
CCO goods and services; other savings - ongoing savings	☒	service	5	5.00	48.89	**1222.25**	
CCO workman's comp	☒	service	931	1.05	520.55	**508863.65**	
CCO goods and services; non-standard items or services, therapies; memberships, FFS	☐	service	120	213.18	42.67	**1091566.87**	
CCO goods and services; other savings - ongoing savings, FFS	☐	service	1	3.00	48.89	**146.67**	
CCO workman's comp, FFS	☐	service	118	1.04	520.55	**63881.90**	
Assistive Devices Total:							**45433.75**
Assistive devices per item; personal care item; adaptive device and therapeutic resources	☒	item	3	0.67	125.00	**251.25**	
Assistive Devices	☒	item	306	1.06	125.00	**40545.00**	
Assistive devices per item; personal care item; adaptive device and therapeutic resources, FFS	☐	item	0	0.00	0.01	**0.00**	
Assistive Devices, FFS	☐	item	35	1.06	125.00	**4637.50**	
Community Transition Services Total:							**542190.00**
Community Transition Services	☒	person	306	1.06	1500.00	**486540.00**	

GRAND TOTAL: **39038381.05**

Total: Services included in capitation: *34673301.41*

Total: Services not included in capitation: *4365079.64*

Total Estimated Unduplicated Participants: **3408**

Factor D (Divide total by number of participants): **11454.92**

Services included in capitation: *10174.09*

Services not included in capitation: *1280.83*

Average Length of Stay on the Waiver: 366

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition Services, FFS	☐	person	35	1.06	1500.00	55650.00	
Family and Community Support Total:							503624.96
Family and Community Support	☒	15 minutes	815	52.61	10.43	447208.67	
Family and Community Support, FFS	☐	15 minutes	104	52.01	10.43	56416.29	
Home and Vehicle Modifications Total:							606427.29
Environmental modifications and adaptive devices (Home Mod)	☒	item	45	1.04	7154.64	334837.15	
Environmental mod and adaptive devices (specialized supply)	☒	item	6	2.50	7154.64	107319.60	
Home and vehicle modification (vehicle only)	☒	item	12	1.08	7154.64	92724.13	
Environmental modifications and adaptive devices (Home Mod), FFS	☐	item	6	1.00	7154.64	42927.84	
Environmental mod and adaptive devices (specialized supply), FFS	☐	item	1	2.00	7154.64	14309.28	
Home and vehicle modification (vehicle only), FFS	☐	item	2	1.00	7154.64	14309.28	
Home-Delivered Meals Total:							1566415.02
Home delivered meals - morning	☒	meal	249	49.33	9.11	111899.68	
Home delivered meals - supplemental meal	☒	meal	243	42.04	5.72	58433.92	
Home Delivered Meals; noon	☒	meal	1324	55.94	9.00	666581.04	
Home delivered	☒					553339.20	

GRAND TOTAL: 39038381.05

Total: Services included in capitation: 34673301.41

Total: Services not included in capitation: 4365079.64

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 11454.92

Services included in capitation: 10174.09

Services not included in capitation: 1280.83

Average Length of Stay on the Waiver: 366

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
meals - evening		meal	1089	55.96	9.08		
Home delivered meals - morning, FFS	☐	meal	33	47.12	9.11	**14165.69**	
Home delivered meals - supplemental meal, FFS	☐	meal	32	40.34	5.72	**7383.83**	
Home Delivered Meals; noon, FFS	☐	meal	169	55.55	9.00	**84491.55**	
Home delivered meals - evening, FFS	☐	meal	138	55.96	9.08	**70120.12**	
Medical Day Care for Children Total:							**257023.82**
Medical Day Care for Children	☒	15 minutes	24	959.17	10.02	**230661.20**	
Medical Day Care for Children, FFS	☐	15 minutes	3	877.00	10.02	**26362.62**	
Peer Mentoring Total:							**36175.00**
Peer Mentoring	☒	15 minutes	50	51.94	12.50	**32462.50**	
Peer Mentoring, FFS	☐	15 minutes	6	49.50	12.50	**3712.50**	
Personal Emergency Response System or Portable Locator System Total:							**115872.96**
Personal emergency response/locator (initial install fee)	☒	installation	8	1.00	51.82	**414.56**	
Personal emergency response/locator (monthly fee)	☒	month	792	3.16	40.94	**102461.36**	
Personal emergency response/locator (initial install fee), FFS	☐	installation	2	0.50	51.82	**51.82**	
Personal emergency response/locator (monthly fee), FFS	☐	month	102	3.10	40.94	**12945.23**	
Positive Behavioral Support and							**391152.86**

GRAND TOTAL: **39038381.05**

Total: Services included in capitation: 34673301.41

Total: Services not included in capitation: 4365079.64

Total Estimated Unduplicated Participants: **3408**

Factor D (Divide total by number of participants): **11454.92**

Services included in capitation: 10174.09

Services not included in capitation: 1280.83

Average Length of Stay on the Waiver: 366

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultation Total:							
Positive Behavioral Support	☒	15 minutes	306	50.67	22.64	**351033.65**	
Positive Behavioral Support, FFS	☐	15 minutes	35	50.63	22.64	**40119.21**	
Transportation Total:							**687176.13**
Transportation; non-emergent wheelchair van; individual; per trip	☒	trip	22	17.45	54.83	**21049.24**	
Transportation; individual (per mile)	☒	mile	1147	66.23	3.11	**236253.67**	
Transportation; one way; individual	☒	1-way trip	323	34.03	32.00	**351734.08**	
Transportation; one way; group	☒	1-way trip	1	37.00	25.60	**947.20**	
Transportation; non-emergent wheelchair van; individual; per trip, FFS	☐	trip	5	9.40	54.83	**2577.01**	
Transportation; individual (per mile), FFS	☐	mile	148	65.06	3.11	**29945.82**	
Transportation; one way; individual, FFS	☐	1-way trip	43	32.37	32.00	**44541.12**	
Transportation; one way; group, FFS	☐	1-way trip	1	5.00	25.60	**128.00**	

GRAND TOTAL: ***39038381.05***

Total: Services included in capitation: *34673301.41*

Total: Services not included in capitation: *4365079.64*

Total Estimated Unduplicated Participants: ***3408***

Factor D (Divide total by number of participants): ***11454.92***

Services included in capitation: *10174.09*

Services not included in capitation: *1280.83*

Average Length of Stay on the Waiver: 366

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:							**14109.08**
Prevocational Services	☒	hour	15	72.00	11.24	**12139.20**	
Prevocational Career Exploration	☒	hour	1	9.00	43.00	**387.00**	
Prevocational Services, FFS	☐	hour	2	68.50	11.24	**1539.88**	
Prevocational Career Exploration, FFS	☐	hour	1	1.00	43.00	**43.00**	
Respite Total:							**23127291.52**
Respite (home health agency; basic individual)	☒	15 minutes	3059	900.13	5.43	**14951492.35**	
Respite (home health agency; specialized)	☒	15 minutes	167	268.90	13.77	**618359.75**	
Respite (home care agency; basic group)	☒	15 minutes	3059	336.11	4.35	**4472498.13**	
Respite (hospital or NF)	☒	15 minutes	30	104.07	11.02	**34405.54**	
Respite (resident camp overnight)	☒	15 minutes	176	467.34	3.97	**326539.80**	
Respite (group day camp)	☒	15 minutes	155	215.39	3.97	**132540.24**	
Respite (home health agency; basic individual), FFS	☐	15 minutes	349	995.63	5.43	**1886788.54**	
Respite (home health agency; specialized), FFS	☐	15 minutes	22	257.55	13.77	**78022.20**	
Respite (home care agency; basic group), FFS	☐	15 minutes	349	371.74	4.35	**564357.08**	
Respite (hospital or NF), FFS	☐	15 minutes	5	78.80	11.02	**4341.88**	
Respite (resident camp overnight), FFS	☐	15 minutes	23	451.39	3.97	**41216.42**	
Respite (group day camp), FFS	☐	15 minutes	20	210.70	3.97	**16729.58**	

GRAND TOTAL: **40784987.46**

Total: Services included in capitation: 36228652.72

Total: Services not included in capitation: 4556334.74

Total Estimated Unduplicated Participants: **3408**

Factor D (Divide total by number of participants): **11967.43**

Services included in capitation: 10630.47

Services not included in capitation: 1336.95

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Total:							**792224.09**
Supported employment (small group) - Tier 1	☒	15 minutes	50	280.74	3.68	**51656.16**	
Supported employment (small group) - Tier 2	☒	15 minutes	10	347.20	2.30	**7985.60**	
Supported Employment (long term job coaching) - Hourly	☒	hour	7	119.14	26.85	**22392.36**	
Supported Employment (long term job coaching) - Tier 1	☒	hour	23	2.09	87.72	**4216.70**	
Supported Employment (long term job coaching) - Tier 2	☒	hour	81	3.28	468.69	**124521.56**	
Supported Employment (long term job coaching) - Tier 3	☒	hour	49	3.29	936.08	**150905.46**	
Supported Employment (long term job coaching) - Tier 4	☒	hour	30	2.17	1463.69	**95286.22**	
Supported Employment (long term job coaching) - Tier 5	☒	hour	52	73.98	58.54	**225201.04**	
Supported Employment (individual employment)	☒	hour	32	8.50	85.73	**23318.56**	
Supported employment (small group) - Tier 1, FFS	☐	15 minutes	7	254.29	3.68	**6550.51**	
Supported employment (small group) - Tier 2, FFS	☐	15 minutes	2	219.50	2.30	**1009.70**	
Supported Employment (long term job coaching) - Hourly, FFS	☐	hour	1	104.00	26.85	**2792.40**	

GRAND TOTAL: ***40784987.46***

Total: Services included in capitation: *36228652.72*

Total: Services not included in capitation: *4556334.74*

Total Estimated Unduplicated Participants: ***3408***

Factor D (Divide total by number of participants): ***11967.43***

Services included in capitation: *10630.47*

Services not included in capitation: *1336.95*

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment (long term job coaching) - Tier 1, FFS	☐	hour	3	2.00	87.72	526.32	
Supported Employment (long term job coaching) - Tier 2, FFS	☐	hour	11	3.00	468.69	15466.77	
Supported Employment (long term job coaching) - Tier 3, FFS	☐	hour	7	2.86	936.08	18740.32	
Supported Employment (long term job coaching) - Tier 4, FFS	☐	hour	3	2.33	1463.69	10231.19	
Supported Employment (long term job coaching) - Tier 5, FFS	☐	hour	7	69.57	58.54	28508.39	
Supported Employment (individual employment), FFS	☐	hour	5	6.80	85.73	2914.82	
Financial Management Services Total:							882828.00
Financial Management Services	☒	fee	946	11.04	75.00	783288.00	
Financial Management Services, FFS	☐	fee	120	11.06	75.00	99540.00	
Independent Support Broker Total:							220788.00
Independent Support Broker	☒	fee	237	11.02	75.00	195880.50	
Independent Support Broker, FFS	☐	fee	30	11.07	75.00	24907.50	
Individual Directed Goods and Services Total:							10783311.40
CCO goods and services; non-standard items or services, therapies; memberships	☒	service	946	223.95	42.68	9042043.96	

GRAND TOTAL: 40784987.46

Total: Services included in capitation: 36228652.72

Total: Services not included in capitation: 4556334.74

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 11967.43

Services included in capitation: 10630.47

Services not included in capitation: 1336.95

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CCO goods and services; other savings - ongoing savings	☒	service	5	5.20	48.89	1271.14	
CCO workman's comp	☒	service	931	1.10	520.55	533095.26	
CCO goods and services; non-standard items or services, therapies; memberships, FFS	☐	service	120	222.72	42.67	1140415.49	
CCO goods and services; other savings - ongoing savings, FFS	☐	service	1	3.00	48.89	146.67	
CCO workman's comp, FFS	☐	service	118	1.08	520.55	66338.89	
Assistive Devices Total:							47182.50
Assistive devices per item; personal care item; adaptive device and therapeutic resources	☒	item	3	0.67	125.00	251.25	
Assistive Devices	☒	item	306	1.10	125.00	42075.00	
Assistive devices per item; personal care item; adaptive device and therapeutic resources, FFS	☐	item	0	0.00	0.01	0.00	
Assistive Devices, FFS	☐	item	35	1.11	125.00	4856.25	
Community Transition Services Total:							563175.00
Community Transition Services	☒	person	306	1.10	1500.00	504900.00	
Community Transition Services, FFS	☐	person	35	1.11	1500.00	58275.00	
Family and Community Support Total:							526128.42
Family and Community Support	☒	15 minutes	815	54.96	10.43	467184.73	

GRAND TOTAL: 40784987.46

Total: Services included in capitation: 36228652.72

Total: Services not included in capitation: 4556334.74

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 11967.43

Services included in capitation: 10630.47

Services not included in capitation: 1336.95

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family and Community Support, FFS	☐	15 minutes	104	54.34	10.43	58943.68	
Home and Vehicle Modifications Total:							637549.97
Environmental modifications and adaptive devices (Home Mod)	☒	item	45	1.09	7154.64	350935.09	
Environmental mod and adaptive devices (specialized supply)	☒	item	6	2.67	7154.64	114617.33	
Home and vehicle modification (vehicle only)	☒	item	12	1.17	7154.64	100451.15	
Environmental modifications and adaptive devices (Home Mod), FFS	☐	item	6	1.00	7154.64	42927.84	
Environmental mod and adaptive devices (specialized supply), FFS	☐	item	1	2.00	7154.64	14309.28	
Home and vehicle modification (vehicle only), FFS	☐	item	2	1.00	7154.64	14309.28	
Home-Delivered Meals Total:							1636561.10
Home delivered meals - morning	☒	meal	249	51.54	9.11	116912.82	
Home delivered meals - supplemental meal	☒	meal	243	43.92	5.72	61047.04	
Home Delivered Meals; noon	☒	meal	1324	58.45	9.00	696490.20	
Home delivered meals - evening	☒	meal	1089	58.46	9.08	578059.50	
Home delivered meals - morning, FFS	☐	meal	33	49.24	9.11	14803.02	
Home delivered meals - supplemental meal, FFS	☐	meal	32	42.16	5.72	7716.97	

GRAND TOTAL: 40784987.46

Total: Services included in capitation: 36228652.72

Total: Services not included in capitation: 4556334.74

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 11967.43

Services included in capitation: 10630.47

Services not included in capitation: 1336.95

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals; noon, FFS	☐	meal	169	58.04	9.00	88278.84	
Home delivered meals - evening, FFS	☐	meal	138	58.46	9.08	73252.72	
Medical Day Care for Children Total:							268515.46
Medical Day Care for Children	☒	15 minutes	24	1002.04	10.02	240970.58	
Medical Day Care for Children, FFS	☐	15 minutes	3	916.33	10.02	27544.88	
Peer Mentoring Total:							37787.75
Peer Mentoring	☒	15 minutes	50	54.26	12.50	33912.50	
Peer Mentoring, FFS	☐	15 minutes	6	51.67	12.50	3875.25	
Personal Emergency Response System or Portable Locator System Total:							120997.02
Personal emergency response/locator (initial install fee)	☒	installation	8	1.00	51.82	414.56	
Personal emergency response/locator (monthly fee)	☒	month	792	3.30	40.94	107000.78	
Personal emergency response/locator (initial install fee), FFS	☐	installation	2	0.50	51.82	51.82	
Personal emergency response/locator (monthly fee), FFS	☐	month	102	3.24	40.94	13529.85	
Positive Behavioral Support and Consultation Total:							408669.89
Positive Behavioral Support	☒	15 minutes	306	52.94	22.64	366759.85	
Positive Behavioral Support, FFS	☐	15 minutes	35	52.89	22.64	41910.04	
Transportation Total:							717868.27

GRAND TOTAL: 40784987.46

Total: Services included in capitation: 36228652.72

Total: Services not included in capitation: 4556334.74

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 11967.43

Services included in capitation: 10630.47

Services not included in capitation: 1336.95

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation; non-emergent wheelchair van; individual; per trip	☒	trip	22	18.23	54.83	21990.12	
Transportation; individual (per mile)	☒	mile	1147	69.19	3.11	246812.49	
Transportation; one way; individual	☒	1-way trip	323	35.55	32.00	367444.80	
Transportation; one way; group	☒	1-way trip	1	39.00	25.60	998.40	
Transportation; non-emergent wheelchair van; individual; per trip, FFS	☐	trip	5	9.80	54.83	2686.67	
Transportation; individual (per mile), FFS	☐	mile	148	67.97	3.11	31285.23	
Transportation; one way; individual, FFS	☐	1-way trip	43	33.81	32.00	46522.56	
Transportation; one way; group, FFS	☐	1-way trip	1	5.00	25.60	128.00	

GRAND TOTAL: 40784987.46
Total: Services included in capitation: 36228652.72
Total: Services not included in capitation: 4556334.74
Total Estimated Unduplicated Participants: 3408
Factor D (Divide total by number of participants): 11967.43
Services included in capitation: 10630.47
Services not included in capitation: 1336.95
Average Length of Stay on the Waiver: 365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:							**14716.04**
Prevocational Services	☒	hour	15	75.20	11.24	**12678.72**	
Prevocational Career Exploration	☒	hour	1	9.00	43.00	**387.00**	
Prevocational Services, FFS	☐	hour	2	71.50	11.24	**1607.32**	
Prevocational Career Exploration, FFS	☐	hour	1	1.00	43.00	**43.00**	
Respite Total:							**24161254.04**
Respite (home health agency; basic individual)	☒	15 minutes	3059	940.37	5.43	**15619893.64**	
Respite (home health agency; specialized)	☒	15 minutes	167	280.92	13.77	**646000.82**	
Respite (home care agency; basic group)	☒	15 minutes	3059	351.14	4.35	**4672497.08**	
Respite (hospital or NF)	☒	15 minutes	30	108.73	11.02	**35946.14**	
Respite (resident camp overnight)	☒	15 minutes	176	488.23	3.97	**341136.07**	
Respite (group day camp)	☒	15 minutes	155	225.03	3.97	**138472.21**	
Respite (home health agency; basic individual), FFS	☐	15 minutes	349	1040.14	5.43	**1971138.11**	
Respite (home health agency; specialized), FFS	☐	15 minutes	22	269.05	13.77	**81506.01**	
Respite (home care agency; basic group), FFS	☐	15 minutes	349	388.36	4.35	**589588.73**	
Respite (hospital or NF), FFS	☐	15 minutes	5	82.40	11.02	**4540.24**	
Respite (resident camp overnight), FFS	☐	15 minutes	23	471.57	3.97	**43059.06**	
Respite (group day camp), FFS	☐	15 minutes	20	220.10	3.97	**17475.94**	

GRAND TOTAL: **42607738.84**

Total: Services included in capitation: *37850215.51*

Total: Services not included in capitation: *4757523.33*

Total Estimated Unduplicated Participants: **3408**

Factor D (Divide total by number of participants): **12502.27**

Services included in capitation: *11106.28*

Services not included in capitation: *1395.99*

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Total:							**826986.79**
Supported employment (small group) - Tier 1	☒	15 minutes	50	293.30	3.68	**53967.20**	
Supported employment (small group) - Tier 2	☒	15 minutes	10	362.70	2.30	**8342.10**	
Supported Employment (long term job coaching) - Hourly	☒	hour	7	124.43	26.85	**23386.62**	
Supported Employment (long term job coaching) - Tier 1	☒	hour	23	2.17	87.72	**4378.11**	
Supported Employment (long term job coaching) - Tier 2	☒	hour	81	3.43	468.69	**130216.14**	
Supported Employment (long term job coaching) - Tier 3	☒	hour	49	3.43	936.08	**157326.97**	
Supported Employment (long term job coaching) - Tier 4	☒	hour	30	2.27	1463.69	**99677.29**	
Supported Employment (long term job coaching) - Tier 5	☒	hour	52	77.29	58.54	**235276.94**	
Supported Employment (individual employment)	☒	hour	32	8.88	85.73	**24361.04**	
Supported employment (small group) - Tier 1, FFS	☐	15 minutes	7	265.71	3.68	**6844.69**	
Supported employment (small group) - Tier 2, FFS	☐	15 minutes	2	229.50	2.30	**1055.70**	
Supported Employment (long term job coaching) - Hourly, FFS	☐	hour	1	109.00	26.85	**2926.65**	

GRAND TOTAL: **42607738.84**

Total: Services included in capitation: 37850215.51

Total: Services not included in capitation: 4757523.33

Total Estimated Unduplicated Participants: **3408**

Factor D (Divide total by number of participants): **12502.27**

Services included in capitation: 11106.28

Services not included in capitation: 1395.99

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment (long term job coaching) - Tier 1, FFS	☐	hour	3	2.00	87.72	526.32	
Supported Employment (long term job coaching) - Tier 2, FFS	☐	hour	11	3.09	468.69	15930.77	
Supported Employment (long term job coaching) - Tier 3, FFS	☐	hour	7	3.00	936.08	19657.68	
Supported Employment (long term job coaching) - Tier 4, FFS	☐	hour	3	2.33	1463.69	10231.19	
Supported Employment (long term job coaching) - Tier 5, FFS	☐	hour	7	72.71	58.54	29795.10	
Supported Employment (individual employment), FFS	☐	hour	5	7.20	85.73	3086.28	
Financial Management Services Total:							922003.50
Financial Management Services	☒	fee	946	11.53	75.00	818053.50	
Financial Management Services, FFS	☐	fee	120	11.55	75.00	103950.00	
Independent Support Broker Total:							230622.75
Independent Support Broker	☒	fee	237	11.51	75.00	204590.25	
Independent Support Broker, FFS	☐	fee	30	11.57	75.00	26032.50	
Individual Directed Goods and Services Total:							11266836.88
CCO goods and services; non-standard items or services, therapies; memberships	☒	service	946	233.97	42.68	9446604.26	

GRAND TOTAL: 42607738.84

Total: Services included in capitation: 37850215.51

Total: Services not included in capitation: 4757523.33

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 12502.27

Services included in capitation: 11106.28

Services not included in capitation: 1395.99

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CCO goods and services; other savings - ongoing savings	☒	service	5	5.40	48.89	1320.03	
CCO workman's comp	☒	service	931	1.15	520.55	557326.86	
CCO goods and services; non-standard items or services, therapies; memberships, FFS	☐	service	120	232.68	42.67	1191414.67	
CCO goods and services; other savings - ongoing savings, FFS	☐	service	1	3.00	48.89	146.67	
CCO workman's comp, FFS	☐	service	118	1.14	520.55	70024.39	
Assistive Devices Total:							49357.50
Assistive devices per item; personal care item; adaptive device and therapeutic resources	☒	item	3	0.67	125.00	251.25	
Assistive Devices	☒	item	306	1.15	125.00	43987.50	
Assistive devices per item; personal care item; adaptive device and therapeutic resources, FFS	☐	item	0	0.00	0.01	0.00	
Assistive Devices, FFS	☐	item	35	1.17	125.00	5118.75	
Community Transition Services Total:							589275.00
Community Transition Services	☒	person	306	1.15	1500.00	527850.00	
Community Transition Services, FFS	☐	person	35	1.17	1500.00	61425.00	
Family and Community Support Total:							549590.39
Family and Community Support	☒	15 minutes	815	57.41	10.43	488010.83	

GRAND TOTAL: 42607738.84

Total: Services included in capitation: 37850215.51

Total: Services not included in capitation: 4757523.33

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 12502.27

Services included in capitation: 11106.28

Services not included in capitation: 1395.99

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family and Community Support, FFS	☐	15 minutes	104	56.77	10.43	**61579.55**	
Home and Vehicle Modifications Total:							**664165.23**
Environmental modifications and adaptive devices (Home Mod)	☒	item	45	1.13	7154.64	**363813.44**	
Environmental mod and adaptive devices (specialized supply)	☒	item	6	2.83	7154.64	**121485.79**	
Home and vehicle modification (vehicle only)	☒	item	12	1.25	7154.64	**107319.60**	
Environmental modifications and adaptive devices (Home Mod), FFS	☐	item	6	1.00	7154.64	**42927.84**	
Environmental mod and adaptive devices (specialized supply), FFS	☐	item	1	2.00	7154.64	**14309.28**	
Home and vehicle modification (vehicle only), FFS	☐	item	2	1.00	7154.64	**14309.28**	
Home-Delivered Meals Total:							**1709627.98**
Home delivered meals - morning	☒	meal	249	53.84	9.11	**122130.12**	
Home delivered meals - supplemental meal	☒	meal	243	45.88	5.72	**63771.36**	
Home Delivered Meals; noon	☒	meal	1324	61.06	9.00	**727590.96**	
Home delivered meals - evening	☒	meal	1089	61.07	9.08	**603867.49**	
Home delivered meals - morning, FFS	☐	meal	33	51.45	9.11	**15467.41**	
Home delivered meals - supplemental meal, FFS	☐	meal	32	44.03	5.72	**8059.25**	

GRAND TOTAL: **42607738.84**

Total: Services included in capitation: 37850215.51

Total: Services not included in capitation: 4757523.33

Total Estimated Unduplicated Participants: **3408**

Factor D (Divide total by number of participants): **12502.27**

Services included in capitation: 11106.28

Services not included in capitation: 1395.99

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals; noon, FFS	☐	meal	169	60.63	9.00	92218.23	
Home delivered meals - evening, FFS	☐	meal	138	61.07	9.08	76523.15	
Medical Day Care for Children Total:							280519.02
Medical Day Care for Children	☒	15 minutes	24	1046.83	10.02	251741.68	
Medical Day Care for Children, FFS	☐	15 minutes	3	957.33	10.02	28777.34	
Peer Mentoring Total:							39475.00
Peer Mentoring	☒	15 minutes	50	56.68	12.50	35425.00	
Peer Mentoring, FFS	☐	15 minutes	6	54.00	12.50	4050.00	
Personal Emergency Response System or Portable Locator System Total:							126445.31
Personal emergency response/locator (initial install fee)	☒	installation	8	1.00	51.82	414.56	
Personal emergency response/locator (monthly fee)	☒	month	792	3.45	40.94	111864.46	
Personal emergency response/locator (initial install fee), FFS	☐	installation	2	0.50	51.82	51.82	
Personal emergency response/locator (monthly fee), FFS	☐	month	102	3.38	40.94	14114.47	
Positive Behavioral Support and Consultation Total:							426897.58
Positive Behavioral Support	☒	15 minutes	306	55.30	22.64	383109.55	
Positive Behavioral Support, FFS	☐	15 minutes	35	55.26	22.64	43788.02	
Transportation Total:							749965.83

GRAND TOTAL: 42607738.84

Total: Services included in capitation: 37850215.51

Total: Services not included in capitation: 4757523.33

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 12502.27

Services included in capitation: 11106.28

Services not included in capitation: 1395.99

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation; non-emergent wheelchair van; individual; per trip	☒	trip	22	19.05	54.83	22979.25	
Transportation; individual (per mile)	☒	mile	1147	72.28	3.11	257835.05	
Transportation; one way; individual	☒	1-way trip	323	37.14	32.00	383879.04	
Transportation; one way; group	☒	1-way trip	1	41.00	25.60	1049.60	
Transportation; non-emergent wheelchair van; individual; per trip, FFS	☐	trip	5	10.20	54.83	2796.33	
Transportation; individual (per mile), FFS	☐	mile	148	71.01	3.11	32684.48	
Transportation; one way; individual, FFS	☐	1-way trip	43	35.33	32.00	48614.08	
Transportation; one way; group, FFS	☐	1-way trip	1	5.00	25.60	128.00	

GRAND TOTAL: 42607738.84
Total: Services included in capitation: 37850215.51
Total: Services not included in capitation: 4757523.33
Total Estimated Unduplicated Participants: 3408
Factor D (Divide total by number of participants): 12502.27
Services included in capitation: 11106.28
Services not included in capitation: 1395.99
Average Length of Stay on the Waiver: 365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:							**15344.92**
Prevocational Services	☒	hour	15	78.53	11.24	**13240.16**	
Prevocational Career Exploration	☒	hour	1	9.00	43.00	**387.00**	
Prevocational Services, FFS	☐	hour	2	74.50	11.24	**1674.76**	
Prevocational Career Exploration, FFS	☐	hour	1	1.00	43.00	**43.00**	
Respite Total:							**25241427.10**
Respite (home health agency; basic individual)	☒	15 minutes	3059	982.41	5.43	**16318193.59**	
Respite (home health agency; specialized)	☒	15 minutes	167	293.48	13.77	**674883.67**	
Respite (home care agency; basic group)	☒	15 minutes	3059	366.84	4.35	**4881411.49**	
Respite (hospital or NF)	☒	15 minutes	30	113.60	11.02	**37556.16**	
Respite (resident camp overnight)	☒	15 minutes	176	510.06	3.97	**356389.12**	
Respite (group day camp)	☒	15 minutes	155	235.08	3.97	**144656.48**	
Respite (home health agency; basic individual), FFS	☐	15 minutes	349	1086.64	5.43	**2059258.86**	
Respite (home health agency; specialized), FFS	☐	15 minutes	22	281.09	13.77	**85153.40**	
Respite (home care agency; basic group), FFS	☐	15 minutes	349	405.72	4.35	**615943.82**	
Respite (hospital or NF), FFS	☐	15 minutes	5	86.00	11.02	**4738.60**	
Respite (resident camp overnight), FFS	☐	15 minutes	23	492.65	3.97	**44983.87**	
Respite (group day camp), FFS	☐	15 minutes	20	229.95	3.97	**18258.03**	

GRAND TOTAL: **44512404.88**

Total: Services included in capitation: 39545203.20

Total: Services not included in capitation: 4967201.68

Total Estimated Unduplicated Participants: **3408**

Factor D (Divide total by number of participants): **13061.15**

Services included in capitation: 11603.64

Services not included in capitation: 1457.51

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Total:							**863909.38**
Supported employment (small group) - Tier 1	☒	15 minutes	50	306.42	3.68	**56381.28**	
Supported employment (small group) - Tier 2	☒	15 minutes	10	378.90	2.30	**8714.70**	
Supported Employment (long term job coaching) - Hourly	☒	hour	7	130.00	26.85	**24433.50**	
Supported Employment (long term job coaching) - Tier 1	☒	hour	23	2.26	87.72	**4559.69**	
Supported Employment (long term job coaching) - Tier 2	☒	hour	81	3.58	468.69	**135910.73**	
Supported Employment (long term job coaching) - Tier 3	☒	hour	49	3.59	936.08	**164665.83**	
Supported Employment (long term job coaching) - Tier 4	☒	hour	30	2.37	1463.69	**104068.36**	
Supported Employment (long term job coaching) - Tier 5	☒	hour	52	80.75	58.54	**245809.46**	
Supported Employment (individual employment)	☒	hour	32	9.28	85.73	**25458.38**	
Supported employment (small group) - Tier 1, FFS	☐	15 minutes	7	277.57	3.68	**7150.20**	
Supported employment (small group) - Tier 2, FFS	☐	15 minutes	2	240.00	2.30	**1104.00**	
Supported Employment (long term job coaching) - Hourly, FFS	☐	hour	1	114.00	26.85	**3060.90**	

GRAND TOTAL: ***44512404.88***

Total: Services included in capitation: *39545203.20*

Total: Services not included in capitation: *4967201.68*

Total Estimated Unduplicated Participants: ***3408***

Factor D (Divide total by number of participants): ***13061.15***

Services included in capitation: *11603.64*

Services not included in capitation: *1457.51*

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment (long term job coaching) - Tier 1, FFS	☐	hour	3	2.00	87.72	526.32	
Supported Employment (long term job coaching) - Tier 2, FFS	☐	hour	11	3.27	468.69	16858.78	
Supported Employment (long term job coaching) - Tier 3, FFS	☐	hour	7	3.14	936.08	20575.04	
Supported Employment (long term job coaching) - Tier 4, FFS	☐	hour	3	2.33	1463.69	10231.19	
Supported Employment (long term job coaching) - Tier 5, FFS	☐	hour	7	76.00	58.54	31143.28	
Supported Employment (individual employment), FFS	☐	hour	5	7.60	85.73	3257.74	
Financial Management Services Total:							963577.50
Financial Management Services	☒	fee	946	12.05	75.00	854947.50	
Financial Management Services, FFS	☐	fee	120	12.07	75.00	108630.00	
Independent Support Broker Total:							241058.25
Independent Support Broker	☒	fee	237	12.03	75.00	213833.25	
Independent Support Broker, FFS	☐	fee	30	12.10	75.00	27225.00	
Individual Directed Goods and Services Total:							11769766.20
CCO goods and services; non-standard items or services, therapies; memberships	☒	service	946	244.43	42.68	9868929.69	

GRAND TOTAL: 44512404.88

Total: Services included in capitation: 39545203.20

Total: Services not included in capitation: 4967201.68

Total Estimated Unduplicated Participants: 3408

Factor D (Divide total by number of participants): 13061.15

Services included in capitation: 11603.64

Services not included in capitation: 1457.51

Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CCO goods and services; other savings - ongoing savings	☒	service	5	5.60	48.89	1368.92	
CCO workman's comp	☒	service	931	1.20	520.55	581558.46	
CCO goods and services; non-standard items or services, therapies; memberships, FFS	☐	service	120	243.08	42.67	1244666.83	
CCO goods and services; other savings - ongoing savings, FFS	☐	service	1	3.00	48.89	146.67	
CCO workman's comp, FFS	☐	service	118	1.19	520.55	73095.63	
Assistive Devices Total:							51532.50
Assistive devices per item; personal care item; adaptive device and therapeutic resources	☒	item	3	0.67	125.00	251.25	
Assistive Devices	☒	item	306	1.20	125.00	45900.00	
Assistive devices per item; personal care item; adaptive device and therapeutic resources, FFS	☐	item	0	0.00	0.01	0.00	
Assistive Devices, FFS	☐	item	35	1.23	125.00	5381.25	
Community Transition Services Total:							615375.00
Community Transition Services	☒	person	306	1.20	1500.00	550800.00	
Community Transition Services, FFS	☐	person	35	1.23	1500.00	64575.00	
Family and Community Support Total:							574191.73
Family and Community Support	☒	15 minutes	815	59.98	10.43	509856.99	

GRAND TOTAL: 44512404.88

Total: Services included in capitation: 39545203.20

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Services included in capitation: 11603.64

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Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family and Community Support, FFS	☐	15 minutes	104	59.31	10.43	**64334.74**	
Home and Vehicle Modifications Total:							**694429.36**
Environmental modifications and adaptive devices (Home Mod)	☒	item	45	1.18	7154.64	**379911.38**	
Environmental mod and adaptive devices (specialized supply)	☒	item	6	3.00	7154.64	**128783.52**	
Home and vehicle modification (vehicle only)	☒	item	12	1.33	7154.64	**114188.05**	
Environmental modifications and adaptive devices (Home Mod), FFS	☐	item	6	1.00	7154.64	**42927.84**	
Environmental mod and adaptive devices (specialized supply), FFS	☐	item	1	2.00	7154.64	**14309.28**	
Home and vehicle modification (vehicle only), FFS	☐	item	2	1.00	7154.64	**14309.28**	
Home-Delivered Meals Total:							**1786067.22**
Home delivered meals - morning	☒	meal	249	56.25	9.11	**127596.94**	
Home delivered meals - supplemental meal	☒	meal	243	47.93	5.72	**66620.78**	
Home Delivered Meals; noon	☒	meal	1324	63.79	9.00	**760121.64**	
Home delivered meals - evening	☒	meal	1089	63.80	9.08	**630862.06**	
Home delivered meals - morning, FFS	☐	meal	33	53.76	9.11	**16161.87**	
Home delivered meals - supplemental meal, FFS	☐	meal	32	46.00	5.72	**8419.84**	

GRAND TOTAL: **44512404.88**

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Total Estimated Unduplicated Participants: **3408**

Factor D (Divide total by number of participants): **13061.15**

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Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals; noon, FFS	☐	meal	169	63.34	9.00	96340.14	
Home delivered meals - evening, FFS	☐	meal	138	63.80	9.08	79943.95	
Medical Day Care for Children Total:							293056.14
Medical Day Care for Children	☒	15 minutes	24	1093.63	10.02	262996.14	
Medical Day Care for Children, FFS	☐	15 minutes	3	1000.00	10.02	30060.00	
Peer Mentoring Total:							41237.25
Peer Mentoring	☒	15 minutes	50	59.22	12.50	37012.50	
Peer Mentoring, FFS	☐	15 minutes	6	56.33	12.50	4224.75	
Personal Emergency Response System or Portable Locator System Total:							131935.36
Personal emergency response/locator (initial install fee)	☒	installation	8	1.00	51.82	414.56	
Personal emergency response/locator (monthly fee)	☒	month	792	3.60	40.94	116728.13	
Personal emergency response/locator (initial install fee), FFS	☐	installation	2	0.50	51.82	51.82	
Personal emergency response/locator (monthly fee), FFS	☐	month	102	3.53	40.94	14740.86	
Positive Behavioral Support and Consultation Total:							446020.00
Positive Behavioral Support	☒	15 minutes	306	57.78	22.64	400290.60	
Positive Behavioral Support, FFS	☐	15 minutes	35	57.71	22.64	45729.40	
Transportation Total:							783476.96

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Services included in capitation: 11603.64

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Average Length of Stay on the Waiver: 365

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation; non-emergent wheelchair van; individual; per trip	☒	trip	22	19.91	54.83	**24016.64**	
Transportation; individual (per mile)	☒	mile	1147	75.51	3.11	**269357.01**	
Transportation; one way; individual	☒	1-way trip	323	38.80	32.00	**401036.80**	
Transportation; one way; group	☒	1-way trip	1	43.00	25.60	**1100.80**	
Transportation; non-emergent wheelchair van; individual; per trip, FFS	☐	trip	5	10.60	54.83	**2905.99**	
Transportation; individual (per mile), FFS	☐	mile	148	74.18	3.11	**34143.57**	
Transportation; one way; individual, FFS	☐	1-way trip	43	36.91	32.00	**50788.16**	
Transportation; one way; group, FFS	☐	1-way trip	1	5.00	25.60	**128.00**	

GRAND TOTAL: ***44512404.88***

Total: Services included in capitation: *39545203.20*

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Average Length of Stay on the Waiver: *365*