

**Home- and  
Community-Based  
Services (HCBS)  
Provider Manual**



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## **CHAPTER III. PROVIDER-SPECIFIC POLICIES**

### **A. Home- and Community-Based Service Waivers**

Medicaid home- and community-based services (HCBS) are federally approved waiver programs available to individuals who meet the required Medicaid-covered level of care provided in a nursing facility, skilled nursing facility, and intermediate care facility for individuals with an intellectual disability, or hospital. The amount, scope, and duration of the waiver programs are limited to what has been approved by the federal government. Members may receive services through fee-for-service or through a Medicaid enrolled Managed Care Organization (MCO).

Individuals must have a need for assistance with activities of daily living or need assistance due to their inability to function independently in their home- or community-related to their disability or age. Once the applicant is approved for the HCBS waiver, an interdisciplinary team is assembled to assist in assessing the needs of the member, identify what services can meet the member's needs, identify who can provide the services, and the amount of services, and cost of services.

If a member selects home- and community-based services, the provision of these services must be based on the assessed service needs of the member and services must be available to meet their needs. The Department requires advance approval for fee-for-service payment under the waivers. The services must also be cost-effective and least costly to meet the needs of the member. Fee-for-service payment will only be made to eligible and enrolled Medicaid HCBS waiver providers. All services and providers must be identified in the service plan for each member accessing waiver services. The Department shall approve the service plan for fee-for-service members.

A record of past and current General Letters outlining the content changes to this chapter is available online at: [http://dhs.iowa.gov/sites/default/files/HCBS\\_GL.pdf](http://dhs.iowa.gov/sites/default/files/HCBS_GL.pdf)

#### **1. Legal Basis**

Section 2176 of OBRA amended the Social Security Act to create the waiver program. The purpose and intent of a Medicaid waiver is stated in Section 1902(c) of the Social Security Act.



The legal basis for Medicaid home- and community-based service waivers is found in Section 1915(c) of the Social Security Act. Public Law 97-35, the Omnibus Budget Reconciliation Act (OBRA) of 1981, contained provisions allowing states to request waivers to provide cost-effective home- and community-based services to eligible people so they can avoid or leave institutionalization.

The OBRA of 1987 established that people residing in nursing homes who meet assessment criteria for specialized services can access waiver programs.

The portions of the Code of Federal Regulations specifically dealing with home- and community-based services are in Title 42, Parts 431.50, 435.3, 435.217, 435.726, 435.735, 440.1, 440.180, 440.250, 441.300 through 441.306, and 441.310. These regulations specify the requirements that the state must meet to be eligible for federal financial participation and, in addition to the Social Security Act, serve as the basis for state law and administrative rules.

All waivers are administered by the designated state Medicaid agency that is Iowa Medicaid. Iowa Medicaid has the authority for the operation of the waiver programs including prior authorization of waiver services.

There are currently seven HCBS waivers that include:

- ◆ AIDS/HIV
- ◆ Brain injury (BI)
- ◆ Children’s mental health (CMH)
- ◆ Elderly (EW)
- ◆ Health and disability (HD)
- ◆ Intellectual disability (ID)
- ◆ Physical disability (PD)

## 2. Definitions

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 83.41(249A)
Brain injury	441 IAC 83.81(249A)
Children’s mental health	441 IAC 83.121(249A)
Elderly	441 IAC 83.21(249A)
Health and disability	441 IAC 83.1(249A)
Intellectual disability	441 IAC 83.60(249A)
Physical disability	441 IAC 83.101(249A)



**“Adaptive”** means age-appropriate skills related to taking care of oneself and the ability to relate to others in daily living situations. These skills address limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional activities of daily living, leisure, and work.

**“Adaptive behavior”** means the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of the individual’s age and social group. Adaptive behavior also refers to the typical performance of individuals without disabilities in meeting environmental expectations.

Adaptive behavior changes according to a person’s age, cultural expectations, and environmental demands. Behaviors are skills related to regulating one’s own actions including:

- ◆ Coping with demands from others,
- ◆ Making choices,
- ◆ Controlling impulses,
- ◆ Conforming conduct to laws, and
- ◆ Displaying appropriate socio-sexual behavior.

**“Adult”** means a person aged 18 years or over.

**“AIDS”** means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control, “Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome,” August 14, 1987, Vol. 36, No. 1S issue of Morbidity and Mortality Weekly Report.”

**“Appropriate”** means that the services or supports or activities provided or undertaken by the organization are relevant and medically necessary to the member’s needs, situation, problems, or desires.

**“Assessment”** means the review of the member’s current functioning in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

**“Attorney-in-fact under a durable power of attorney for health care”** means an individual designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

**“Basic individual respite”** means respite provided on one staff-to-one member ratio without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

**“Benefits education”** means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for Employed Persons with Disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians, and legal representatives.

**“Blind individual”** means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

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

- ◆ Malignant neoplasms of brain, cerebrum
- ◆ Malignant neoplasms of brain, frontal lobe
- ◆ Malignant neoplasms of brain, temporal lobe
- ◆ Malignant neoplasms of brain, parietal lobe
- ◆ Malignant neoplasms of brain, occipital lobe
- ◆ Malignant neoplasms of brain, ventricles
- ◆ Malignant neoplasms of brain, cerebellum
- ◆ Malignant neoplasms of brain, brain stem
- ◆ Malignant neoplasms of brain, other part of brain includes midbrain, peduncle, and medulla oblongata
- ◆ Malignant neoplasms of brain, cerebral meninges
- ◆ Malignant neoplasms of brain, cranial nerves
- ◆ Secondary malignant neoplasm of brain
- ◆ Secondary malignant neoplasm of other parts of the nervous system including cerebral meninges

- ◆ Benign neoplasm of brain and other parts of the nervous system, brain
- ◆ Benign neoplasm of brain and other parts of the nervous system, cranial nerves
- ◆ Benign neoplasm of brain and other parts of the nervous system, cerebral meninges
- ◆ Encephalitis, myelitis, and encephalomyelitis
- ◆ Intracranial and intraspinal abscess
- ◆ Anoxic brain damage
- ◆ Subarachnoid hemorrhage
- ◆ Intracerebral hemorrhage
- ◆ Other and unspecified intracranial hemorrhage
- ◆ Occlusion and stenosis of precerebral arteries
- ◆ Occlusion of cerebral arteries
- ◆ Transient cerebral ischemia
- ◆ Acute, but ill-defined, cerebrovascular disease
- ◆ Other and ill-defined cerebrovascular diseases
- ◆ Fracture of vault of skull
- ◆ Fracture of base of skull
- ◆ Other and unqualified skull fractures
- ◆ Multiple fractures involving skull or face with other bones
- ◆ Concussion, chronic traumatic encephalopathy
- ◆ Cerebral laceration and contusion
- ◆ Subarachnoid, subdural, and extradural hemorrhage following injury
- ◆ Other and unspecified intracranial hemorrhage following injury
- ◆ Intracranial injury of other and unspecified nature
- ◆ Poisoning by drugs, medicinal, and biological substances
- ◆ Toxic effects of substances
- ◆ Effects of external causes
- ◆ Drowning and nonfatal submersion
- ◆ Asphyxiation and strangulation

- ◆ Child maltreatment syndrome
- ◆ Adult maltreatment syndrome

“**Care coordinator**” means the professional who assists members in care coordination as described in paragraph 78.53(1)“b.”

“**Career exploration**,” also referred to as “career planning,” means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program members to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a member in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the member’s stated career objective and a career plan used to guide individual employment support.

“**Career plan**” means a written plan documenting the member’s stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state’s minimum wage.

“**Case management**” means services provided according to rule 441 IAC 90.5(249A) and 441 IAC 90.8(249A).

“**Certified employment specialist**” or “**CES**” means a person who has demonstrated a sufficient level of knowledge and skill to provide integrated employment support services to a variety of client populations and has earned a CES certification through a nationally recognized accrediting body.

“**Child**” means a person aged 17 or under.

“**Client participation**” means the amount of the member’s income that the person must contribute to the cost of waiver services, exclusive of medical vendor payments, before Medicaid will participate.

“**CMS**” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“**Community**” means a natural setting where people live, learn, work, and socialize.

“**Comprehensive service plan**” means an individualized, goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.



“**Core Standardized Assessment (CSA)**” is a tool for gathering information from the individuals in the same HCBS population by asking a standard set of questions about basic functional skills and abilities. CSA tools are designed to be welcoming and easy to use, identify the strengths and support needs of the individual, and take into account the opinions of the individual, as well as the needs of the person’s family and caregivers.

“**Counseling**” means face-to-face mental health services provided to the member and caregiver by a qualified mental health professional as defined pursuant to rule 441 IAC 24.61(225C), to facilitate home management of the member and prevent institutionalization.

“**Customized employment**” means an approach to supported employment which individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer.

Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

“**Deemed status**” means acceptance by the Department of Accreditation or Licensure of a program or service by another accrediting body in lieu of accreditation based on review and evaluation by the Department.

“**Deeming**” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“**Department**” means the Iowa Department of Human Services.

“**Direct service**” means therapy, habilitation, rehabilitation activities or support services provided face-to-face to a member within their home or community.

“**Emergency**” means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.



“**Financial participation**” means client participation and medical payments from a third-party including veterans’ aid and attendance.

“**Fiscal accountability**” means the development and maintenance of budgets and independent fiscal review.

“**Group respite**” is respite provided on a ratio of one staff-to-two or more members.

“**Guardian**” means a guardian appointed in court.

“**HCBS**” means home- and community-based services.

“**Health**” means a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. This includes the maintenance of one’s health including:

- ◆ Diet and nutrition.
- ◆ Illness identification, treatment and prevention.
- ◆ Basic first aid.
- ◆ Physical fitness.
- ◆ Regular health and wellness screenings; and
- ◆ Personal habits.

“**HIV**” means a medical diagnosis of human immunodeficiency virus infection that attacks the immune system, the body’s natural defense system, based on a positive HIV-related test.

“**Immediate family member**” means a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

“**Immediate jeopardy**” means circumstances where it has caused, or is likely to cause, serious injury, harm, impairment, or death to an individual if the circumstances are not immediately corrected.

“**Individual employment**” means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above 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.



**“Individual placement and support”** means an evidence-based supported employment model that helps people with mental illness to seek and obtain employment.

**“Integrated community employment”** means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and which presents opportunities for advancement that are similar to those for employees who are not disabled.

In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

**“Institution for mental disease”** means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

**“Integrated health home (IHH)”** means a designated provider of health home services that is a Medicaid- or MCO-enrolled provider and that is determined through the provider enrollment process to have the qualifications, systems and infrastructure in place to provide integrated health home services pursuant to 441 IAC 77.47(240A). Integrated health home covered services and member eligibility for integrated health home enrollment is pursuant to 441 IAC 78.53(249A).

**“Intellectual disability”** means a diagnosis of intellectual disability (intellectual development disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person’s condition was during the developmental period and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills.



The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.

**“Intermediate care facility for persons with an intellectual disability (ICF/ID)”** means 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. § 1936d, which are contained in 42 C.F.R. pt. 483, subpart D, § 410 - 480.

**“Interdisciplinary team”** means a collection of persons with varied backgrounds chosen by the member who meet with the member to develop a service plan to meet the member’s need for services. At a minimum, the member and case manager must be part of the interdisciplinary team.

**“Intermittent supported community living service”** means supported community living service provided for not more than 52 hours per month.

**“IoWANS”** is the Iowa Department of Human Services’ *Institutional and Waiver Authorization and Narrative System*.

The purpose of IoWANS is to assist workers in the facility and waiver programs in both processing and tracking requests starting with entry from the ABC system through approval or denial.

**“Living unit”** means a single dwelling unit such as an apartment or house.

**“Local office”** means the county Department of Human Services office as described in rule 441 IAC 1.4(2).

**“Licensed practical nurse (LPN)”** means a person licensed to practice nursing in the state of Iowa according to Iowa Code 152.7.

**“Maintenance needs”** means costs associated with rent or mortgage, utilities, telephone, food, and household supplies.



**“Major incident”** means an occurrence involving a member that is enrolled in the HCBS waiver or Habilitation and that:

1. Results in a physical injury to or by the member that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a member’s location being unknown by provider staff who are assigned protective oversight.

**“Minor incident”** means an occurrence involving a member during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error

**“Managed Care Organization (MCO)”** means an HMO contracted with the Department of Human Services to provide Iowa Medicaid members with comprehensive health care services, including physical health, behavioral health, and long-term services and supports.

**“Medical assessment”** means a visual and physical screening of the member by an appropriately licensed professional, noting deviations from the norm, and a statement of the member’s mental and physical condition. Evaluation of the disease or condition based on the member’s subjective report of the symptoms and course of the illness or condition and the examiner’s objective findings, including:

- ◆ Data obtained through laboratory tests,



- ◆ Physical examination,
- ◆ Medical history, and
- ◆ Information reported by family members and other health care team members.

**“Medical institution”** means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

**“Medical intervention”** means to improve the mental, emotional, or physical functioning of a member’s care in the areas of:

- ◆ Hygiene,
- ◆ Mental and physical comfort,
- ◆ Assistance in feeding and elimination, and
- ◆ Control of the member’s care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

**“Medical monitoring”** means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member’s plan of care.

**“Medical necessity”** means the provision of medically necessary medical care, services or supplies while exercising reasonable and prudent clinical judgment. Reasonable and prudent clinical judgment considers whether the care, services or supplies are being provided to a member for the purpose of:

- ◆ Evaluating,
- ◆ Diagnosing,
- ◆ Preventing, or
- ◆ Treating an illness, injury, disease or its symptoms.
- ◆ Services shall be in accordance with standard of good medical practices as determined by DHS or its designated representative. Medically necessary care, services, or supplies shall:
  - ◆ Be consistent with the diagnosis and treatment of the member’s condition.
  - ◆ Be clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the member’s illness, injury or disease.
  - ◆ Be in accordance with standards of good medical practice and not considered experimental or investigational.



- ◆ Be required to meet the medical need of the member and be for reasons other than the convenience of the member or the member’s practitioner or caregiver.
- ◆ Be the least costly type of service which would reasonably meet the medical need of the member.
- ◆ Be eligible for federal financial participation unless specifically covered by state law or rule.
- ◆ Be prescribed or provided with the scope of the licensure of the provider.
- ◆ Be provided with full knowledge and consent of the member or someone acting on the member’s behalf unless otherwise required by law or court order or in emergency situations.
- ◆ Be supplied by a provider who is eligible to participate in the Medicaid program.

“**Member**” means a person who is eligible for Medicaid under rule 441 IAC Chapter 75.

“**Mental health professional**” means a person who meets all of the following conditions:

- ◆ Holds at least a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a Doctor of Medicine or osteopathic medicine; and
- ◆ Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and
- ◆ Has at least two years of post-degree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

“**Natural supports**” means services and supports an individual identifies as wanted or needed that are provided at no cost by family, friends, neighbors, and others in the community, or by organizations or entities that serve the general public at no cost to the Medicaid program.

“**Non-legal representative**” means an individual who has been freely chosen by the member to assist the member with the consumer choices option, and who is not:

- ◆ A legally appointed guardian of an adult child,
- ◆ A conservator,



- ◆ An attorney-in-fact under a durable power of attorney for health care, or
- ◆ A power of attorney for financial matters, trustee, or representative payee.

A non-legal representative may have budget authority over the individual budget if so authorized by the member.

**“Nursing facility”** means an institution or a distinct part of an institution housing, which is primarily engaged in providing health-related care and services, including rehabilitative services, but which is not engaged primarily in providing treatment or care for mental illness or an intellectual disability. The nursing facility provides continuous nursing care and supervision under the direction of a physician. It is limited to persons who have a physical or mental impairment which restricts their ability to perform essential activities of daily living as outlined in criteria and impede their capacity to live independently. Their physical or mental impairment are such that self-execution of the required nursing care is improbable or impossible.

**“Physical disability”** means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities:

- ◆ Self-care,
- ◆ Receptive and expressive language,
- ◆ Learning,
- ◆ Mobility,
- ◆ Self-direction,
- ◆ Capacity for independent living, and
- ◆ Economic self-sufficiency.

**“Plan of care”** means the individualized goal-oriented plan of services developed collaboratively with the member and the service provider. The plan of care is reflective of the service plan developed by the case manager, IHH, or MCO with the member and the interdisciplinary team.

**“Policies”** means the principles and statements of intent of the organization.

**“Procedures”** means the steps taken to implement the policies of the organization.

**“Process”** means service or support provided by an agency to a member that will allow the member to achieve an outcome. This may include a written, formal, consistent or an informal method that is not written but is a verifiable method.

“**Program**” means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

“**Psychiatric medical institutions for children (PMIC)**” means a psychiatric medical institution for children that use a team of professionals to direct an organized program of diagnostic services, psychiatric services, nursing care, and rehabilitative services to meet the needs of residents in accordance with a medical care plan developed for each resident.

“**Qualified brain injury professional**” means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years’ experience working with people living with a brain injury:

- ◆ Psychologist.
- ◆ Psychiatrist.
- ◆ Physician.
- ◆ Registered nurse.
- ◆ Certified teacher.
- ◆ Social worker.
- ◆ Mental health counselor.
- ◆ Physical, occupational, recreational, speech therapist; or
- ◆ A person with a Bachelor of Arts or science degree in psychology, sociology, or public health or rehabilitation services.

“**Qualified intellectual disability professional**” means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

- ◆ A Doctor of Medicine or osteopathy;
- ◆ A registered nurse;
- ◆ An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body;
- ◆ A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body;



- ◆ A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification;
- ◆ A psychologist with a master’s degree in psychology from an accredited school;
- ◆ A social worker with a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body or who holds a Bachelor of Social Work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body;
- ◆ A professional recreation staff member with a bachelor’s degree in recreation or in a specialty area such as art, dance, music or physical education.
- ◆ A professional dietitian eligible for registration by the American Dietetic Association; or
- ◆ A human services professional that must have at least a bachelor’s degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling or psychology.

“**Registered nurse (RN)**” means a person licensed to practice nursing in the state of Iowa according to Iowa Code Chapter 152.

“**Rehabilitation services**” means services designed to restore, improve, or maximize the individual’s optimal level of functioning, self-care, self-responsibility, independence, and quality of life and to minimize impairments, related to the identified disabilities.

“**Related condition**” means persons who have a severe, chronic disability that meets all the following conditions:

- ◆ It is attributable to cerebral palsy or epilepsy or any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of an intellectual disability and requires treatment or services similar to those required for these persons; and
- ◆ It is manifested before the person reaches the age of 22; and



- ◆ It is likely to continue indefinitely; and
- ◆ Results in substantial functional limitations in three or more of the following areas of major life activities:
  - Self-care
  - Understanding and use of language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living

**“Residential care facility for persons with mental illness (RCF/PMI)”** means a licensed facility that provides accommodation, board, personal assistance and other essential daily living activities to three or more individuals with mental illness for a period exceeding 24 hours.

Members must be able to sufficiently or properly care for themselves, but do not require the services of a registered or licensed practical nurse. These facilities emphasize individualized program planning in an aggressive effort to assist members to a more independent way of life. (Definition is found in Iowa Code Chapter 135C.)

**“Self-direction”** means the opportunity for members or their representatives to exercise choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider, and location of service provision.

**“Serious emotional disturbance”** means a diagnosable mental, behavioral, or emotional disorder that:

- ◆ Is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association; and
- ◆ Has resulted in a functional impairment that substantially interferes with or limits a member’s role or functioning in family, school, or community activities.

Serious emotional disturbance shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as “other conditions that may be a focus of clinical attention,” unless these conditions co-occur with another diagnosable serious emotional disturbance.



**“Service coordination”** means activities designed to help individuals and families locate, access, and coordinate a network of natural supports and services that will allow them to live a full life in the community. Included are using natural supports and services, other payment sources, and state plan use before the use of waiver services to provide the most cost-effective coordination for the member.

**“Service plan”** means an individualized goal-oriented plan of services written in a language understandable by the member or the member’s representative using the service and developed collaboratively by the individual and the interdisciplinary team.

**“Skill development”** means that the service provided is intended to impart an ability or capacity to the member.

**“Skilled nursing facility”** means a facility as defined in 42 CFR 483.5.

**“Specialized respite”** means respite provided on a one staff-to-one member ratio or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

**“Staff”** means a person under the direction of the organization to perform duties and responsibilities of the organization.

**“Substantial gainful activity”** means productive activities that add to the economic wealth or produce goods or services to which the public attaches a monetary value.

**“Supported employment”** means the ongoing supports to members who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.



**“Supported self-employment”** includes services and supports that assist the member in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include:

- ◆ Aid to the member in identifying potential business opportunities;
- ◆ Assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;
- ◆ Identification of the supports necessary for the member to operate the business; and
- ◆ Ongoing assistance, counseling, and guidance once the business has been launched.

**“Sustained employment”** means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

**“Targeted case management”** means services furnished to assist members who are part of a targeted population and who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other services in order to ensure the health, safety, and welfare of the members. Case management is provided to a member on a one-to-one basis by one case manager.

**“Third-party payments”** means payments from an attorney, individual, institution, corporation, or public or private agency that is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

**“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.

**“Visit”** means a home health aide or nursing encounter that is zero (0) to two (2) hours in duration.



### 3. Service Eligibility

#### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 83.42(249A)
Brain injury	441 IAC 83.82(249A)
Children’s mental health	441 IAC 83.122(249A)
Elderly	441 IAC 83.22(249A)
Health and disability	441 IAC 83.2(249A)
Intellectual disability	441 IAC 83.61(249A)
Physical disability	441 IAC 83.102(249A)

Services are available and reimbursable only for people who meet eligibility criteria, which include meeting the designated level of care for the waiver. A Department of Human Services income maintenance worker determines that the member meets Medicaid criteria for income and resources.

The member must be certified as needing nursing facility, skilled nursing facility, or hospital level of care or as needing care in an intermediate care facility for the intellectually disabled. The Iowa Medicaid Medical Services Unit shall be responsible for approval of the certification of the initial level of care (LOC) and any subsequent LOC changes. An MCO may be involved with subsequent LOC reviews.

Eligibility under the waivers is based on the following:

- ◆ Income and resource criteria
- ◆ Age, disability, or medical need
- ◆ Level of institutional care needed
- ◆ Need for waiver services
- ◆ A determination that the cost of the waiver program does not exceed the established cost limit for the member’s level of care. Waiver services are beyond the scope of the Medicaid state plan. Services provided under waivers are not available to other Medicaid members. Provision of these services must be cost-neutral.

Waiver services will not be provided when the member is an inpatient in a medical institution.



#### 4. Slot Assignment

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Brain injury	441 IAC 83.82(4)
Children’s mental health	441 IAC 83.123(1)
Health and disability	441 IAC 83.3(2)
Intellectual disability	441 IAC 83.61(3)
Physical disability	441 IAC 83.102(3)

Each of the waivers has an allocated number of slots that applicants may access. The income maintenance worker (IMW) is responsible for securing the slot under each of the waivers.

When a payment slot is available, Iowa Medicaid assigns the slot to the applicant. Once assigned an assessment will be scheduled and performed, either by the applicant’s MCO or the department assessment contractor if the applicant is not MCO enrolled. Case managers can attend the assessment if requested by the applicant. If an applicant is granted waiver eligibility and is IHH or MCO enrolled, the IHH or MCO will be responsible for service planning. A FFS case manager is responsible for service planning for those members that are not eligible for MCO enrollment.

When there is no available slot, the Department will reject the application, but the applicant’s name is maintained on the applicable waiting list. Applicants placed in the Intellectual Disability Waiver waiting list will be sent form [470-5110, Priority Needs Assessment](#).

Applicants placed on the Brain Injury Waiver waiting list will be sent form 470-5583 BI Waiver Emergency Needs Assessment form. If the applicant has emergent or urgent needs, that information should be included on the form and returned to the Department. The Department will review the form to determine if the emergent or urgent needs will cause the applicant to be placed higher on the waiting list.



## **5. Reserved Capacity Slots**

### **a. BI Waiver Reserved Capacity Slots**

The state reserves a number of BI Waiver funding slots each year for members living in an ICF/ID, nursing facility or out of state placement, with plans to return to Iowa, has lived there for at least six months, and chooses the BI waiver program over institutional services.

The state reserves a number of BI Waiver funding slots each year for members receiving residential Community-based Neurobehavioral Rehabilitation Services (CNRS) for at least six months and chooses the BI Waiver program over institutional services.

### **b. CMH Waiver Reserved Capacity Slots**

The state reserves a number of CMH Waiver funding slots each year for members living in a mental health institute (MHI), psychiatric medical institution for children (PMIC), psychiatric residential treatment facility (PRTF) or other out of state institutional care, who has lived there for six months, and chooses to access services in the CMH waiver program and leaves the facility to reside in the family home.

### **c. ID Waiver Reserved Capacity Slots**

The state reserves a number of ID Waiver funding slots each year for children under the age of 18 that will receive Residential Based Supported Community Living (RBSCL) services outside of the family home and chooses the ID waiver program over institutional services.

The state reserves a number of ID Waiver funding slots each year for use by members living in an ICF/ID, nursing facility, or out of state placement with plans to return to Iowa, who choose to access services in the ID Waiver program.

The state reserves a number of ID Waiver funding slots each year for use by members accessing the Money Follows the Person (MFP) grant as they transition from MFP funding to the ID waiver after one year of MFP funding.



Reserved Capacity Slots are available for use by any eligible person for the ID waiver program that currently resides in an ICF/ID, nursing facility or out of state placement with plans to return to Iowa, has lived there for at least six months, and chooses the ID waiver program over institutional services.

**d. Accessing a Reserved Capacity Slot**

The member must make application for the waiver at the local DHS office. When applying, the member must request a reserved capacity slot from the IM worker. If an IM receives a request for a reserved capacity slot, they will pend the waiver application and then they must enter into the comment section in IoWANS "this request is for a reserved capacity slot", and then the Slot manager will respond in IoWANS to the milestone asking if a slot is available indicating that the member will be diverted from a facility and that a slot is available.

If the member has not initiated services within 60 days of access to the funding slot, the slot will revert to the next member that has requested the reserved capacity funding slot

## 6. Summary of Waiver Services

The following comparison chart identifies the services available under each HCBS waiver:

Services by Program	AIDS/HIV	BI	CMH	EW	HD	ID	PD
Adult day care	X	X		X	X	X	
Assisted living				X			
Assistive devices				X			
Behavioral programming		X					
Case management services		X		X			
Chore				X			
Consumer choices option (CCO)	X	X		X	X	X	X
Consumer-directed attendant care (CDAC)	X	X		X	X	X	X
Counseling	X				X		
Day habilitation						X	
Environmental modification and adaptive devices			X				
Family and community support			X				
Family counseling and training		X					
Home-delivered meals	X			X	X		
Home health aide	X			X	X	X	
Homemaker	X			X	X		
Home/vehicle modification		X		X	X	X	X
In-home family therapy			X				
Interim medical monitoring and treatment (IMMT)		X			X	X	
Mental health outreach				X			
Nursing	X			X	X	X	
Nutritional counseling				X	X		



Services by Program	AIDS/HIV	BI	CMH	EW	HD	ID	PD
Personal emergency response		X		X	X	X	X
Prevocational services		X				X	
Respite services	X	X	X	X	X	X	
Senior companion				X			
Specialized medical equipment		X					X
Supported community living (SCL)		X				X	
Supported community living residential-based (RBSCL)						X	
Supported employment (SE)		X				X	
Transportation		X		X		X	X

**7. Waiver Prior Authorization**

HCBS service requests that exceed the median cost (units) of each waiver service must be reviewed and approved by Iowa Medicaid.

The Iowa Medicaid Medical Services Unit may request additional information from the case manager via a *Certificate of Medical Necessity* form or other documents such as the service or treatment plan, itemized estimates, service schedules, etc. The Medical Services Unit will need to receive all requested materials before making a decision.

For waiver members enrolled in managed care, the member’s MCO must review and approve the request for services.

## **8. Person-Centered Service Planning**

The member shall have a service plan approved by the Department which is developed by the interdisciplinary team. This must be completed before service provision and annually thereafter or more often if there is a change in the member's needs.

At initial enrollment the case manager or integrated health home shall:

- ◆ Establish the interdisciplinary team with input from the member. The team will identify the member's "need for service" based on the member's needs and desires as well as the availability and appropriateness of services.
- ◆ The case manager or integrated health home shall complete an annual review thereafter.
- ◆ In addition to the service plan, each service provider must document the activities associated with implementing the goals identified in the service plan.

The following criteria are used for the initial and ongoing assessments:

- ◆ Members aged 17 or under shall receive services based on development of adaptive, behavioral, or health skills.
- ◆ Service plans must be developed or reviewed, to reflect use of all appropriate non-waiver services, so as not to replace or duplicate services.

### **Interdisciplinary Team**

An interdisciplinary team must include the member and either the case manager, integrated health home, and other persons designated by the member. Other persons on the team may be:

- ◆ The parents when the member is a minor.
- ◆ The member's legally authorized representative.
- ◆ The member's family unless the family's participation is limited by court order or is contrary to the wishes of the adult member who has not been legally determined to be unable to make decisions independently.
- ◆ All current service providers.



- ◆ Any other professional representation including, but not limited to:
  - Vocational rehabilitation counselors,
  - Court appointed mental health advocates,
  - Correction officers,
  - Educators, and
  - Other professionals as appropriate.
- ◆ Persons identified by the member or family, provided the family's wishes are not in conflict with the desires of the member.

The team shall be convened to develop the initial service plan and to revise the service plan, at least annually or whenever there is a significant change in the member's needs or conditions.

## 9. HCBS Waiver Comprehensive Service Plan

Services must be included in a comprehensive person-centered service plan. The comprehensive person-centered service plan must be developed through a person-centered planning process driven by the member in collaboration with the member's interdisciplinary team, as established with the case manager or integrated health home coordinator.

The member's comprehensive service plan must be updated at least annually, when a change in the member's circumstances or needs change significantly, or at the request of the member.

### **The comprehensive person-centered planning process:**

- ◆ Includes people chosen by the member.
- ◆ Provides necessary information and support to the member to ensure that the member directs the process to the maximum extent possible.
- ◆ Is timely and occurs at times and locations of convenience to the member.
- ◆ Reflects cultural considerations and uses plain language.
- ◆ Includes strategies for solving a disagreement.
- ◆ Offers choices to the member regarding services and supports the member receives and from whom.
- ◆ Provides method to request updates.
- ◆ Conducted to reflect what is important to the member to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.

- ◆ Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the member.
- ◆ May include whether services are self-directed and which services are self-directed.
- ◆ Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others.
- ◆ Includes risk factors and plans to minimize them.
- ◆ Is signed by all individuals and providers responsible for its implementation and a copy of the plan must be provided to the member and the member's representative.

**The HCBS waiver written comprehensive service plan documentation:**

- ◆ Reflects the member's strengths and preferences
- ◆ Reflects clinical and support needs
- ◆ Includes observable and measurable goals and desired outcomes:
  - Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.
  - Identify the staff people, businesses, or organizations responsible for carrying out the interventions or supports.
- ◆ Identifies for a member receiving supported community living services:
  - The member's living environment at the time of enrollment,
  - The number of hours per day of direct staff supervision needed by the member, and
  - The number of other members who will live with the member in the living unit.
- ◆ Reflects providers of services and supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS, including:
  - Name of the provider
  - Service authorized
  - Units of service authorized
- ◆ Includes risk factors and measures in place to minimize risk
- ◆ Includes individualized backup plans and strategies when needed.
  - Identify any health and safety issues that apply to the member based on information gathered before the team meeting, including a risk assessment.



- Identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.
- Providers of applicable services shall provide for emergency backup staff.
- ◆ Includes the names of the individuals responsible for monitoring the plan.
- ◆ Is written in plain language and understandable to the member.
- ◆ Documents who is responsible for monitoring the plan.
- ◆ Documents due process and the informed consent of the member for any restrictive interventions, behavioral intervention plans, the planned use of restraints and restrictions, Due process includes identification of the restriction and, the need for the restriction, identification of other, less restrictive interventions that have been tried, a plan to lessen or eliminate the restrictions or written documentation that a plan is not necessary or appropriate.
- ◆ All restrictive interventions must be time limited and reviewed for continued necessity by at least quarterly.
- ◆ Includes the signatures of all individuals and providers responsible
- ◆ Is distributed to the member and others involved in the plan
- ◆ Includes purchase and control of self-directed services
- ◆ Excludes unnecessary or inappropriate services and support

Any rights restrictions must be implemented in accordance with 441 IAC 77.25(4) and 78.27. These requirements include but are not limited to:

- ◆ Informed consent of the member or member's legal guardian.
- ◆ Documentation of any and all rights restrictions in the HCBS member's person-centered comprehensive service plan or treatment plan.
- ◆ Documentation of any service specific restrictions in the HCBS provider's service specific service plan or treatment plan for the member.
- ◆ Documentation of a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
- ◆ Regular collection and review of data to measure the ongoing effectiveness of the restriction



## 10. Adverse Service Actions

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 83.48(249A)
Brain injury	441 IAC 83.88(249A)
Children’s mental health	441 IAC 83.128(249A)
Elderly	441 IAC 83.28(249A)
Health and disability	441 IAC 83.8(249A)
Intellectual disability	441 IAC 83.68(249A)
Physical disability	441 IAC 83.108(249A)

This section contains the conditions that will result in:

- ◆ [Denial of an individual’s application for waiver services,](#)
- ◆ [Reduction of the amount of waiver services provided,](#) or
- ◆ [Termination of waiver eligibility.](#)

### a. Denial of Application

#### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 83.48(1)
Brain injury	441 IAC 83.88(1)
Children’s mental health	441 IAC 83.128(1)
Elderly	441 IAC 83.28(1)
Health and disability	441 IAC 83.8(1)
Intellectual disability	441 IAC 83.68(1)
Physical disability	441 IAC 83.108(1)

The Department shall deny an application for services when it determines that:

- ◆ The member is not eligible for or in need of services.
- ◆ Service needs exceed the service unit or reimbursement maximums.
- ◆ Service needs are not met by the services provided.
- ◆ Needed services are not available or received from qualifying providers.
- ◆ The HCBS waiver service is not identified in the member’s service plan.



- ◆ There is another community resource available to provide the service or a similar service free of charge to the member that will meet the member’s needs.
- ◆ The Department has not received required documents for the member.
- ◆ The member receives services from other Medicaid waiver programs.
- ◆ The member or legal representative requests termination from the services.

**b. Reduction of Service**

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 83.48(3)
Brain injury	441 IAC 83.88(2)
Children’s mental health	441 IAC 83.128(3)
Elderly	441 IAC 83.28(3)
Health and disability	441 IAC 83.8(3)
Intellectual disability	441 IAC 83.68(2)
Physical disability	441 IAC 83.108(2)

The Department may reduce a particular waiver service when it determines either of the following:

- ◆ Continued provision of service at its current level is not necessary. The Department must determine the level to which the service may be reduced without jeopardizing the member’s continued progress toward achieving or maintaining the goal.
- ◆ Another community resource is available to provide the same or similar service to the member at no financial cost to the member that will meet the member’s needs.



**c. Termination of Service**

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 83.48(2)
Brain injury	441 IAC 83.88(3)
Children’s mental health	441 IAC 83.128(2)
Elderly	441 IAC 83.28(2)
Health and disability	441 IAC 83.8(2)
Intellectual disability	441 IAC 83.68(3)
Physical disability	441 IAC 83.108(3)

A particular service may be terminated when the Department determines that:

- ◆ The specific need to attain the goals and objectives to which the service was directed has been achieved.
- ◆ After repeated assessment, it is evident that the family or member is unable to achieve or maintain the goals set forth in the individual member’s service plan.
- ◆ After repeated efforts, it is evident that the family or member is unwilling to accept further service.
- ◆ The member’s income or resources exceed the financial guidelines.
- ◆ Another community resource is available to provide the service or a similar service free of charge to the member that will meet the member’s needs.
- ◆ The member refuses to allow documentation of eligibility as to need, income, and resources.
- ◆ Needed services are not available or received from qualifying providers.
- ◆ The HCBS waiver service is not identified in the member’s annual service plan.
- ◆ The member’s service needs are not met by the services provided.
- ◆ Needed services exceed the service unit or reimbursement maximums.
- ◆ The Department has not received required documents for the member.



- ◆ The member receives services from other Medicaid waiver programs that meet the member’s assessed needs.
- ◆ The member or legal representative through the interdisciplinary process requests termination from services.
- ◆ The member receives care in a hospital, nursing facility, or intermediate care facility for the intellectually disabled for 30 days in any one stay for purposes other than respite care.

## B. Waiver Service Descriptions

The services included in this section are available to members enrolled in both fee-for-service and MCO. Any noted limitations in this manual apply to fee-for-service. Providers serving members enrolled with an MCO should discuss service limitations with the applicable MCO.

### 1. Adult Day Care

#### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 78.38(7)
Brain injury	441 IAC 78.43(9)
Elderly	441 IAC 78.37(1)
Health and disability	441 IAC 78.34(3)
Intellectual disability	441 IAC 78.41(12)

Adult day care services provide an organized program of supportive care in a group environment to people who need a degree of supervision and assistance on a regular or intermittent basis in a day care center.

Components of this service may include:

- ◆ Health-related care
- ◆ Social services
- ◆ Other related support services

The cost of transportation to and from the day care site may be included in the provider’s rate.



## 2. Assisted Living

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Elderly	441 IAC 78.37(13)

The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver members who reside in a homelike, non-institutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision.

Assisted living service is not reimbursable if performed at the same time as any service included in an approved Consumer-Directed Attendant Care (CDAC) agreement.

- ◆ A unit of service is one day.
- ◆ A day of assisted living service is billable only if both the following requirements are met:
  - The member was present in the facility during that day's bed census.
  - The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with 441 IAC 79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized CDAC service.

## 3. Assistive Devices

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Elderly	441 IAC 78.37(13)

Assistive devices means practical equipment to assist members with activities of daily living and instrumental activities of daily living to allow the member more independence. Devices include, but are not limited to:

- ◆ Long-reach brush
- ◆ Extra-long shoehorn
- ◆ Non-slip grippers to pick up and reach items
- ◆ Dressing aids
- ◆ Transfer boards
- ◆ Shampoo rinse tray and inflatable shampoo tray
- ◆ Double-handled cup and sipper lid



#### 4. Behavioral Programming

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Brain injury	441 IAC 78.43(12)

Behavioral programming consists of individually designed strategies to increase the member’s appropriate behaviors and decrease the member’s maladaptive behaviors that have interfered with the member’s ability to remain in the community. Behavioral programming includes:

- ◆ A complete assessment of both appropriate and maladaptive behaviors.
- ◆ Development of a structured behavioral plan, which should be identified in the member’s individual treatment plan.
- ◆ Implementation of the behavioral intervention plan.
- ◆ Ongoing training and supervision to caregivers and behavioral aides.
- ◆ Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to:

- ◆ Clinical redirection
- ◆ Token economies
- ◆ Reinforcement
- ◆ Extinction
- ◆ Modeling
- ◆ Over-learning

#### 5. Brain Injury Waiver Case Management

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Brain injury	441 IAC 78.43(1), 441 IAC 90

Payment for waiver case management shall not be made until the member is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the member during a month when the member is enrolled in the waiver. Members who are eligible for TCM through state plan Medicaid receive TCM in addition to waiver services and do not receive case management as a waiver service. Members who also receive state plan habilitation services (1915(i)) will receive case management through the habilitation program and not through the brain injury waiver.

For the brain injury waiver, “individual case management services” means activities provided, using an interdisciplinary process, to members with a brain injury to:

- ◆ Ensure that the member has received an evaluation and diagnosis,
- ◆ Give assistance to the member in obtaining appropriate services and living arrangements,
- ◆ Coordinate the delivery of services, and
- ◆ Provide monitoring to ensure the continued appropriate provision of services and the appropriateness of the selected living arrangement.

BI case management services shall consist of the following components as detailed in IAC Chapter 90:

- ◆ Intake, which includes ensuring that there is sufficient information to identify all areas of need for services and appropriate living arrangements.
- ◆ Assurance that a service plan is developed which addresses the member’s total needs for services and living arrangements.
- ◆ Assistance to the member in obtaining the services and living arrangements identified in the service plan.
- ◆ Coordination and facilitation of decision making among providers to ensure consistency in the implementation of the service plan.
- ◆ Monitoring of the services and living arrangements to ensure their continued appropriateness for the member.
- ◆ Crisis assistance to facilitate referral to the appropriate providers to resolve the crisis.
- ◆ One face-to-face contact with the member in the member’s residence at least quarterly.
- ◆ One contact per month with the member, the member’s legally authorized representative, this contact may be face-to-face or by telephone.

The intent and purpose of the individual case management services are to facilitate the member’s access to the service system and to enable members and their families to make decisions on their own behalf by providing:

- ◆ Information necessary for decision making.
- ◆ Assistance with decision-making and participation in the decision-making process affecting the member.



- ◆ Assistance in problem solving.
- ◆ Assistance in exercising the member’s rights.

The service is to be delivered to enhance the capabilities of members and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the member to:

- ◆ Exercise choice,
- ◆ Make decisions,
- ◆ Take risks which are a typical part of life, and
- ◆ Fully participate as a member of the community.

It is essential that the case manager develop a relationship with the member so that the abilities, needs and desires of the member can be clearly identified and communicated, and the case manager can help to ensure that the system and specific services are responsive to the needs of the members.

## 6. Elderly Waiver Case Management

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Elderly	441 IAC 77.33(21), 441 IAC 90

Payment for waiver case management shall not be made until the member is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the member during a month when the member is enrolled in the waiver. Members who are eligible for targeted case management through state plan Medicaid receive TCM in addition to waiver services and do not receive case management as a waiver service. Members who also receive state plan habilitation services (1915(i)) will receive case management through the habilitation program and not through the elderly waiver.

Under the elderly waiver, case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services to ensure the health, safety, and welfare of the member.



Case management is provided at the direction of the member and the interdisciplinary team according to the standards as detailed in IAC Chapter 90. Covered services include:

- ◆ Participation in the assessment and reassessment of the member’s needs if requested by the member,
- ◆ Development and review of the member’s service plan,
- ◆ Service referral and related activities,
- ◆ Monitoring and follow-up to ensure:
  - The health, safety, and welfare of the member; and
  - Effective implementation of a service plan that adequately addresses the needs of the member.
- ◆ One face-to-face contact with the member in the member’s residence at least quarterly.
- ◆ One contact per month with the member or the member’s legally authorized representative. This contact may be face-to-face or by telephone
- ◆ A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver members.

## 7. Chore Service

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Elderly	441 IAC 77.37(249A)

Chore services provide assistance with the household maintenance activities as necessary to allow a member to remain in the member’s own home safely and independently.

Chore services include the following services:

- ◆ Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows
- ◆ Minor repairs to walls, floors, stairs, railings, and handles
- ◆ Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal
- ◆ Lawn mowing and removal of snow and ice from sidewalks and driveways



Chore services **do not** include leaf raking, bush and tree trimming, trash burning, stick removal, or tree removal.

## 8. Consumer-Directed Attendant Care (CDAC)

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS/HIV	441 IAC 78.38(8)
Brain injury	441 IAC 78.43(13)
Elderly	441 IAC 78.37(15)
Health and disability	441 IAC 78.34(7)
Intellectual disability	441 IAC 78.41(8)
Physical disability	441 IAC 78.46(1)

Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks that the member would typically do independently if the member were otherwise able. Consumer-directed attendant care services must be cost-effective and necessary to prevent institutionalization.

Members who request consumer-directed attendant care (CDAC) and for whom the interdisciplinary team agrees that CDAC is an appropriate service shall have CDAC included in their service plan.

The member or the legal representative is responsible for:

- ◆ Selecting the person or agency that will provide the components of the attendant care services.
- ◆ Determining the components of the attendant care services to be provided with the person who is providing the services to the member.
- ◆ Completing form [470-3372, HCBS Consumer-Directed Attendant Care Agreement](#), with the provider and signing it. Form 470-3372 must be provided to and signed by the case manager before services begin.

NOTE: Each provider that is providing the CDAC service must complete and sign a separate *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372.



Members will give direction and training for activities to maintain independence that are not medical in nature. Licensed nurses and therapists will provide on-the-job training and supervision for skilled activities described in form 470-3372. When CDAC is part of the member’s service plan, a copy of the completed form 470-3372 becomes an attachment to and part of the service plan.

Before the provision of services, the case manager must review and approve form 470-3372 for appropriateness of the services and the number of units of service identified as well as the provider’s training and experience. (As the state Medicaid agency, DHS has oversight responsibility for CDAC providers.)

Refer to the previous section on waiver prior authorization (see [Waiver Prior Authorization](#)). It is recommended that provisions be made for alternate providers to supplement service provision for emergencies that may arise. These alternate providers should be enrolled and designated in the written service plan. This will allow the alternate service providers to assume the service provision immediately whenever necessary.

**a. Covered Services**

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 78.38(8)
Brain injury	441 IAC 78.43(13)
Elderly	441 IAC 78.37(15)
Health and disability	441 IAC 78.34(7)
Intellectual disability	441 IAC 78.41(8)
Physical disability	441 IAC 78.46(1)

All consumer-directed attendant care services are supportive services.

**Non-skilled service activities** may include helping the member with any of the following activities:

- ◆ Bathing, shampooing, hygiene, and grooming.
- ◆ Tasks, such as handling money and scheduling, which require cognitive or physical assistance.
- ◆ Communication essential to the health and welfare of the member, through interpreting and reading services, and use of assistive devices for communication.
- ◆ Dressing.

- ◆ Housekeeping, laundry, and shopping essential to the member's health care at home.
- ◆ Meal preparation, cooking, eating and feeding. Meal preparation and cooking shall be provided only in the member's home.

**NOTE:** The actual cost of meals is not included.

- ◆ Taking medications ordinarily self-administered, including medications ordered by a physician or other qualified health care provider.
- ◆ Minor wound care.
- ◆ Going to and from place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included.
- ◆ Access to and from bed or wheelchair, transferring, or ambulating.
- ◆ Toileting needs, including bowel, bladder and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- ◆ Using transportation essential to the health and welfare of the member, but not the cost of transportation for the member or the provider.

**Skilled** service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician:

- ◆ Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist
- ◆ Care of uncontrolled medical conditions, such as brittle diabetes and comfort care of terminal conditions
- ◆ Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required
- ◆ Colostomy care
- ◆ Intravenous therapy administered by a licensed nurse
- ◆ Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., anti-hypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics

- ◆ Parenteral injections required more than once a week
- ◆ Post-surgical care
- ◆ Preparing and monitoring response to therapeutic diets
- ◆ Recording and reporting changes in vital signs to the nurse or therapist
- ◆ Rehabilitation services, including:
  - Ambulation training
  - Behavior modification
  - Bowel and bladder training
  - Range-of-motion exercises
  - Reality orientation
  - Reminiscing therapy
  - Re-motivation
  - Respiratory care and breathing programs
  - Restorative nursing services
  - Re-teaching the activities of daily living
- ◆ Respiratory care, including inhalation therapy and tracheotomy care or tracheotomy care and ventilator
- ◆ Tube feedings of members unable to eat solid foods

The licensed nurse or therapist must ensure appropriate assessment, planning implementation, and evaluation for skilled consumer-directed attendant care services. The licensed nurse or therapist must make on-site supervisory visits every two weeks with the provider present.

The cost of the supervision provided by the licensed nurse or therapist must be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the Care for Kids program before accessing the HCBS waiver.

## **b. Relationship to Other Services**

When a member has a CDAC service, the CDAC provider cannot receive respite services. An alternative CDAC provider may be used to provide the CDAC services.

Members may be eligible for both a HCBS waiver and the state supplementary assistance in-home health-related care program when:

- ◆ They meet the eligibility requirements of each program, and
- ◆ Each program provides a different service or supplements the HCBS waiver.

CDAC may not be provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care service.

## **c. Excluded Services and Costs**

Services, activities, costs, and time that are not covered as consumer-directed attend care include the following (not an exclusive list):

- ◆ Any activity related to supervising a member. Only direct services are billable.
- ◆ Any activity that the member is able to perform.
- ◆ Costs of food.
- ◆ Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including nursing, home health and early and periodic screening, diagnosis and treatment services.
- ◆ Exercise that does not require skilled services.
- ◆ Parenting or childcare for or on behalf of the member.
- ◆ Reminders and cueing.
- ◆ Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- ◆ Transportation costs.
- ◆ Wait times for any activity.



## 9. Consumer Choices Option (CCO) Services

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS/HIV	441 IAC 78.38(9)
Brain injury	441 IAC 78.43(15)
Elderly	441 IAC 78.37(16)
Health and disability	441 IAC 78.34(13)
Intellectual disability	441 IAC 78.41(15)
Physical disability	441 IAC 78.46(6)

The consumer choices option provides a member with a flexible monthly individual budget that is based on the member’s service needs.

Within the individual budget amount, the member shall have the authority to purchase goods and services and hires providers of service and supports. Components of this service are set forth below:

- ◆ **Required service components.** To participate in the consumer choices option, a member must:
  - Hire an independent support broker, and
  - Work with a financial management service provider that is enrolled as a Medicaid HCBS waiver service provider.
- ◆ **Optional service components.** A member who elects the consumer choices option may purchase the following services and supports, which shall be provided in the member’s home or at an integrated community setting:
  - Self-directed personal care services
  - Self-directed community supports and employment
  - Individual-directed goods and services

A monthly individual budget amount is established for each member based on the assessed needs of the member and the waiver services authorized in the member’s service plan. Once authorized, a member may convert a waiver service to create a CCO budget.



The waiver services that may be converted to a CCO budget:

Services by Program	AIDS/HIV	BI	EW	HD	ID	PD
Assistive devices			X			
Chore			X			
Consumer-directed attendant care, unskilled	X	X	X	X	X	X
Day habilitation					X	
Home-delivered meals	X		X	X		
Homemaker	X		X	X		
Home/vehicle modification		X	X	X	X	X
Prevocational services		X			X	
Respite services, basic individual	X	X	X	X	X	
Senior companion			X			
Specialized medical equipment		X				X
Supported community living (SCL)		X			X	
Supported employment (SE)		X			X	
Transportation		X	X		X	X

Once selected, the waiver services are entered into the member’s service plan for use in CCO. IOWANS will automatically calculate a monthly “cap amount” and a “budget amount” based on the type and amount of waiver service entered into the service plan.

The cap amount is used to ensure the member stays within the program dollar limits such as the monthly level of care cap or the annual respite cap in the ID waiver. The budget amount is the amount of funds available to the member to purchase goods and services to meet the member’s assessed needs. The member is notified by the case manager of the initial budget amount and any change to the monthly budget amount.

The member will use the monthly budget amount to purchase goods and services to meet their assessed needs. The member's assessed needs are considered the type and amount of waiver services that were authorized in the service plan to create the CCO budget. For example, CDAC services are authorized in the plan and converted to a CCO budget, the budget must be used to meet CDAC needs that have been assessed as needed by the member.

The member using CCO is self-directing their services. This means they have both budget and employer authority. A member has the authority to hire and fire employees, establish wages and purchase goods and services to get their needs met. If a member is efficient in using the monthly budget to get all their assessed needs met and there are additional budget funds remaining, they can use the funds to purchase additional goods and services in the current month or put the funds into a saving account for use in future months.

#### **CCO Services and Transportation:**

- ◆ SCL and transportation may be provided and reimbursed simultaneously when using CCO.
- ◆ The member's case manager must identify the need for transportation and authorize the service(s) to meet the transportations need.
- ◆ When using CCO, the member may pay for the SCL service and transportation simultaneously, like an enrolled Medicaid SCL provider that includes transportation costs in their rates; both the service and transportation may be provided and billed at the same time.
- ◆ When ID or BI waiver SCL services are authorized in the member's service plan and converted to the monthly CCO budget, transportation costs are included in the CCO budget. The member, acting under the CCO budget and employer authority has the flexibility to use the monthly budget and their employees to get their needs met. This could include:
  - paying employees for mileage,
  - paying employees, a per trip rate,
  - pay a higher hourly rate when transportation is provided,
  - purchase of gas.



- ◆ As noted above, there are IAC service rules that dictate what services a Case Manager can authorize in a member’s service plan. A case manager is responsible to assess the need for transportation and authorize the service(s) to meet the need. Once the service(s) are authorized in the member’s plan and converted to a CCO monthly budget, the member is responsible to use the monthly budget to purchase goods and services to meet all assessed needs authorized in the service plan. The member has control over the use of the monthly budget and can pay for SCL and transportation services simultaneously.

## 10. Counseling

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS/HIV	441 IAC 78.38(1)
Health and disability	441 IAC 78.34(6)

Counseling services are face-to-face non-psychiatric mental health services necessary for:

- ◆ The management of depression,
- ◆ Assistance with the grief process,
- ◆ Alleviation of psychosocial isolation, and
- ◆ Support to cope with a disability or illness, including terminal illness.

Counseling services can be provided to the member and caregiver to facilitate home management of the member and prevent institutionalization. NOTE: Counseling services may be provided to the member’s caregiver only when included in the member’s approved service plan documented in IOWANS.

Counseling services may be provided both for the purposes of:

- ◆ Training the member’s family or other caregiver to provide care, and
- ◆ Helping the member and those caring for the member to adjust to the member’s disability or terminal condition.

Services must be provided by a mental health professional. Providers may be:

- ◆ Certified community mental health centers,
- ◆ Licensed or Medicaid enrolled hospices, or
- ◆ Accredited mental health services providers.



Payment will be made for individual and group counseling. Group counseling is based on the group rate divided by six, or, if the number of people in the group exceeds six, by the actual number of people who comprise the group.

## 11. Day Habilitation

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Intellectual disability	441 IAC 78.41(14)

“Day habilitation” means services that provide opportunities and support for community inclusion and build interest in and develop skills for active participation in recreation, volunteerism and integrated community employment. Day habilitation provides assistance with acquisition, retention, or improvement of socialization, community participation, and daily living skills.

Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or maintain the member’s individual goals as identified in the member’s comprehensive service plan.

Services may also provide wraparound support secondary to community employment. Day habilitation must be furnished in an integrated community setting.

Day habilitation activities may include:

- (1) Identifying the member’s interests, preferences, skills, strengths and contributions,
- (2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,
- (3) Planning and coordination of the member’s individualized daily and weekly day habilitation schedule,
- (4) Developing skills and competencies necessary to pursue competitive integrated employment,
- (5) Participating in community activities related to hobbies, leisure, personal health, and wellness,



- (6) Participating in community activities related to cultural, civic, and religious interests,
- (7) Participating in adult learning opportunities,
- (8) Participating in volunteer opportunities,
- (9) Training and education in self-advocacy and self-determination to support the member’s ability to make informed choices about where to live, work, and recreate,
- (10) Assistance with behavior management and self-regulation,
- (11) Use of transportation and other community resources,
- (12) Assistance with developing and maintaining natural relationships in the community,
- (13) Assistance with identifying and using natural supports,
- (14) Assistance with accessing financial literacy and benefits education,
- (15) Other activities deemed necessary to assist the member with full participation in the community, developing social roles and relationships, and increasing independence and the potential for employment

**Family training option**

Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member’s home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month

**Expected outcome of service**

The expected outcome of day habilitation services is active participation in the community in which the member lives, works, and recreates. Members are expected to have opportunities to interact with individuals without disabilities in the community, other than those providing direct services, to the same extent as individuals without disabilities.

**Setting**

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



### **Duration**

Day habilitation services shall be furnished as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

### **Unit of service**

A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

### **Concurrent services**

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

### **Transportation**

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

### **Exclusions**

Day habilitation payment shall not be made for the following:

- (1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

- (2) Compensation to members for participating in day habilitation.
- (3) Support for members volunteering in for-profit organizations and businesses.
- (4) Support for members volunteering to benefit the day habilitation service provider.



- (5) Indirect services such as meetings, documentation or collateral contacts.
- (6) Day habilitation may not be provided to members under the age of 16.

**Day habilitation is not allowable for:**

- ◆ Providers who do not meet the provider qualifications for day habilitation due to a lack of accreditation from the Department of Human Services under 441 Chapter 24 to provide day treatment, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Quality and Leadership (the Council).
- ◆ Instances when a provider is not providing for, and delivering an organized program of, skill development in accordance with the member’s comprehensive service plan developed by the case manager.
- ◆ Activities which do not meet the Medicaid definition for day habilitation, including supervision and time, while the member is asleep and not participating in day habilitation services, as defined in the IAC.
- ◆ Insufficient or non-existent documentation to support the amount of time billed to Medicaid.

**12. Environmental Modification and Adaptive Devices**

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Children’s mental health	441 IAC 78.52(2)

Environmental modifications and adaptive devices include items installed or used within the member’s home that address specific, documented health, mental health, or safety concerns.

For each unit of service provided, the Integrated health home or MCO shall maintain in the member’s case file a signed statement from a mental health professional on the member’s interdisciplinary team that the service has a direct relationship to the member’s diagnosis of serious emotional disturbance. The cost of approved environmental modification and adaptive devices is not included in the total monthly cap for services under the waiver.



### 13. Family and Community Support Services

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Children’s mental health	441 IAC 78.52(3)

Family and community support services shall support the member and the member’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 member’s and the family’s social and emotional strength.

Dependent on the needs of the member and the member’s family members individually or collectively, family and community support services may be provided to the member, to the member’s family members, or to the member and the family members as a family unit.

Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member’s interdisciplinary team.

Family and community support services shall incorporate recommended support interventions, which may include the following:

- ◆ Developing and maintaining a crisis support network for the member and for the member’s family
- ◆ Modeling and coaching effective coping strategies for the member’s family
- ◆ Building resilience to the stigma of serious emotional disturbance for the member and the family
- ◆ Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members
- ◆ Modeling and coaching the strategies and interventions identified in the member’s crisis intervention plan as defined in 441 IAC 24.1(225C) for life situations with the member’s family and in the community
- ◆ Developing medication management skills
- ◆ Developing personal hygiene and grooming skills that contributes to the member’s positive self-image
- ◆ Developing positive socialization and citizenship skills



Family and community support services may include an amount not to exceed the upper limit per 441 IAC 79.1(15)“b” (8) per member per year limit in rule for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

- ◆ The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included it in the service plan.
- ◆ The annual amount available for transportation and therapeutic resources must be listed in the member’s service plan.
- ◆ The member’s parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member’s family or legal guardian.
- ◆ The member’s Medicaid case manager or integrated health home 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.
- ◆ 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:

- ◆ Vocational services
- ◆ Prevocational services
- ◆ Supported employment services
- ◆ Room and board
- ◆ Academic services
- ◆ General supervision and member care

#### **14. Family Counseling and Training**

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Brain injury	441 IAC 78.43(10)

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



Family counseling and training may be provided by:

- ◆ Community mental health centers
- ◆ Hospices (licensed or certified under Medicare)
- ◆ Accredited mental health service providers
- ◆ Qualified brain injury professionals

“Family” may include spouse, children, friends, or in-laws of the member. It does not include people who are employed to care for the member.

Counseling may include the use of treatment regimens as specified in the individual treatment plan. Periodic training updates may be necessary to safely maintain the member in the community.

Counseling may include helping the member or family members with:

- ◆ Crisis
- ◆ Coping strategies
- ◆ Stress reduction
- ◆ Management of depression
- ◆ Alleviation of psychosocial isolation
- ◆ Support in coping with the effects of a brain injury

## 15. Financial Management Service (FMS)

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 78.38(9) “I”
Brain injury	441 IAC 78.43(15) “I”
Elderly	441 IAC 78.37(16) “I”
Health and disability	441 IAC 78.34(13) “I”
Intellectual disability	441 IAC 78.41(15) “I”
Physical disability	441 IAC 78.46(6) “I”

Members who elect the consumer choices option shall work with an FMS provider that meets the following qualifications.



The FMS provider shall either:

- ◆ Be a cooperative, nonprofit, member-owned and member-controlled, and federally insured financial institution through and chartered by either the National Credit Union Administration (NCUA) or the Credit Union Division of the Iowa Department of Commerce; or
- ◆ 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).

The FMS shall complete a financial management readiness review and certification conducted by the Department or its designee.

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

The FMS shall enroll as a Medicaid provider and as an MCO provider as applicable.

Before initiation of a consumer choices option service, the member and the employee must enter the designated financial institution on form [470-4428, Financial Management Service Agreement](#).

The FMS shall perform all the following services:

- ◆ Receive Medicaid funds in an electronic transfer
- ◆ Process and pay invoices for approved goods and services included in the individual budget
- ◆ Enter the individual budget into the Web-based tracking system chosen by the Department and enter expenditures as they are paid
- ◆ Provide real-time individual budget account balances for the member, the independent support broker, and the Department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday)
- ◆ Conduct criminal background checks on potential employees pursuant to 441 IAC Chapter 119
- ◆ Verify for the member an employee's citizenship or alien status



- ◆ Assist the member with fiscal and payroll-related responsibilities, including but not limited to:
  - Verifying those hourly wages comply with federal and state labor rules.
  - Collecting and processing timecards.
  - Withholding, filing, and paying federal, state, and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  - Computing and processing other withholdings, as applicable.
  - Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  - Preparing and issuing employee payroll checks.
  - Preparing and disbursing IRS forms W-2 and W-3 annually.
  - Processing federal advance earned income tax credit for eligible employees.
  - Refunding over-collected FICA, when appropriate.
  - Refunding over-collected FUTA, when appropriate.
  - Assisting the member in completing required federal, state, and local tax and insurance forms.
  - Establishing and managing documents and files for the member and the member's employees.
  - Monitoring timecards, receipts, and invoices to ensure that they are consistent with the individual budget.
  - Keeping records of all timecards and invoices for each member for a total of five years.
  - Providing 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.
  - Establishing an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
  - Establishing a customer services complaint reporting system.
  - Developing a policy and procedures manual that is current with state and federal regulations and update, as necessary.



- Developing a business continuity plan in the case of emergencies and natural disasters.
- Providing to the Department an annual independent audit of the financial management service.
- Assisting in implementing the state’s quality management strategy related to the financial management service.

## 16. Home and Vehicle Modification

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Brain injury	441 IAC 78.43(5)
Elderly	441 IAC 78.37(9)
Health and disability	441 IAC 78.34(9)
Intellectual disability	441 IAC 78.41(4)
Physical disability	441 IAC 78.46(2)

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

Modifications that are necessary or desirable without regard to the member’s medical or remedial need and that would be expected to increase the fair market value of the home or vehicle are excluded except as specifically included below. (Examples include furnaces, fencing, roof repair, or adding square footage to the residence.) Repairs are also excluded.

Only the following modifications are covered:

- ◆ Kitchen counters, sink space, cabinets, and special adaptations to refrigerators, stoves, and ovens
- ◆ Bathtubs and toilets to accommodate transfer, special handles and hoses for showerhead, water faucet controls, and accessible showers and sinks
- ◆ Ramps, lifts, turnaround space adaptations, grab bars and handrails, new door openings, pocket doors, and widening of doors, halls, and windows
- ◆ Modification of existing stairs to widen, lower, raise, or enclose open stairs
- ◆ Low-pile carpeting or slip-resistant flooring and exterior hard-surface pathways



- ◆ Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle
- ◆ Heightening of existing garage door opening to accommodate modified van
- ◆ Keyless entry systems, automatic opening device for home or vehicle door, specialized doorknobs and handles, and special door and window locks
- ◆ Fire safety alarm equipment specific for disability
- ◆ Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability
- ◆ Telecommunications device for the deaf
- ◆ Plexiglas replacement for glass windows
- ◆ Installation or relocation of controls, outlets, switches, or motion detectors
- ◆ Air conditioning and air filtering, if medically necessary

Services shall be included in the member's service plan and shall exceed the Medicaid state plan services. Services shall be performed following prior approval of the modification as specified in 441 IAC 79.1(17) and a binding contract between the provider and the member. Service payment is made to the provider following the completion of the approved modifications. All modifications and adaptations must be in accordance with applicable federal, state, and local building and vehicle codes.

Annual limits for home and vehicle modifications may be located in 441 IAC 79.1(2).

All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include:

- ◆ The scope of work to be performed,
- ◆ The time involved,
- ◆ Supplies needed,
- ◆ The cost,
- ◆ Diagrams of the project whenever applicable, and
- ◆ An assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.



For fee-for-service members the case manager shall submit the certificate of medical necessity, the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid Medical Services Unit for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member’s medical needs.

Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment may be made to certified providers upon satisfactory completion of the service.

The cost of approved home and vehicle modification is not included in the total monthly cap for services under the waiver.

## **17. Home-Delivered Meals**

### **Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 78.38(6)
Elderly	441 IAC 78.37(8)
Health and disability	441 IAC 78.34(11)

Home-delivered meals means meals prepared elsewhere and delivered to a member at the member’s residence.

Each meal shall ensure the member receives a minimum of one-third of the daily-recommended dietary allowance, as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

A unit of service is one meal.

A maximum of 2 meals per day or 14 meals per week is allowed.



When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance

For billing purposes, meals are broken down as follows:

- ◆ Morning meal
- ◆ Noon meal
- ◆ Evening meal
- ◆ Liquid supplement

## 18. Home Health Aide

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 78.38(2)
Elderly	441 IAC 78.37(3)
Health and disability	441 IAC 78.34(2)
Intellectual disability	441 IAC 78.41(6)

Home health aide services are unskilled medical services that provide direct personal care. This service may include:

- ◆ Observation and reporting of physical or emotional needs.
- ◆ Assistance with bathing, shampooing (including pediculosis shampooing), or oral hygiene.
- ◆ Assistance with toileting.
- ◆ Assistance with ambulation.
- ◆ Helping a member in and out of bed.
- ◆ Re-establishing activities of daily living (including range of motion exercises).
- ◆ Assisting with oral medications ordinarily self-administered and ordered by a physician (including application of medicinal skin cream).
- ◆ In order to complete a full unit of service, performing incidental household services that are essential to the member's health care at home and necessary to prevent or postpone institutionalization.
- ◆ For the HD waiver, accompanying a member to medical services or transport to and from school.



Home health aide daily care may be provided for members who are employed or attending school whose disabling conditions require them to be assisted with morning and evening activities of daily living. Services are to be provided in the home.

Home health services **do not** include:

- ◆ Homemaker services, such as cooking and cleaning.
- ◆ Assistance with homework assignments.
- ◆ Services that meet the intermittent guidelines under Medicaid.
- ◆ Services that are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) authority.

Services may not duplicate any regular Medicaid or waiver services provided under the state plan.

Home health aide services are available to members under the age of 21 through Care for Kids (EPSDT). For members aged 21 or over, the waiver provides coverage for home health aide services that are needed beyond the intermittent home health aide services available through regular Medicaid.

“Intermittent” home health aide services may include up to 28 hours of service per week when services are medically necessary. Intermittent home health aide services must be accessed before waiver home health aide services.

For the **HD** waiver, a nurse may provide home health services in some cases if the health of the member is such that either:

- ◆ The agency is unable to place an aide in that situation due to limitations by state law, or
- ◆ The agency’s Medicare certification requirements prohibit the aide from providing the service.
- ◆ It is not permitted for the convenience of the provider.

For the **ID and BI** waiver, waiver home health aide services must exceed those activities provided under supported community living. Instruction, supervision, support, or assistance in personal hygiene, bathing, and daily living are activities provided under supported community living.

The defined duration of a visit/encounter is zero (0) - two (2) hours.



The per visit unit of service is applicable to the following HCBS Waiver services:

HCBS Waiver Service	Waiver Program(s)	Procedure Code	Unit of Service	Maximum Units
Home Health Aide	AIDS/HIV Elderly Health and Disability	T1021	Per Visit	As medically necessary and within the monthly cap for the AIDS/HIV and Health and Disability Waivers.

**19. Homemaker Service**

**Legal reference:**

Waiver Type	Corresponding Iowa Administrative Code
AIDS/HIV	441 IAC 78.38(3)
Elderly	441 IAC 78.37(4)
Health and disability	441 IAC 78.34(1)

Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. (The person who usually performs these functions for the member may be incapacitated or be occupied providing direct care to the member.)

Components of the service are directly related to the care of the member and include only the following:

- ◆ Shopping for basic needs items such as food, clothing or personal care items, or drugs
- ◆ Maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes
- ◆ Planning and preparing balanced meals

## 20. Independent Support Broker

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS/HIV	441 IAC 78.38(9) "k"
Brain injury	441 IAC 78.43(15) "k"
Elderly	441 IAC 78.37(16) "k"
Health and disability	441 IAC 78.34(13) "k"
Intellectual disability	441 IAC 78.41(15) "k"
Physical disability	441 IAC 78.46(6) "k"

To participate in the consumer choices option, a member must select an independent support broker who meets the following qualifications:

- ◆ The broker must be at least 18 years of age.
- ◆ The broker shall not be the:
  - Member's legal representative;
  - Member's guardian, conservator, attorney-in-fact under a durable power of attorney for health care;
  - Power of attorney for financial matters, trustee, or representative payee.
- ◆ The broker shall not provide any other paid service to the member.
- ◆ The broker shall not work for an individual or entity that is providing services to the member.
- ◆ The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
- ◆ The broker must complete an independent support brokerage certification approved by the Department.
- ◆ The member (and the member's personal representative, if any) and the independent support broker must complete form [470-4492, Independent Support Broker Agreement](#), to formalize the terms of the relationship.



The independent support broker shall perform the following services as directed by the member or the member’s representative:

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

The payment rate may be negotiated between the member and the broker. The independent support broker may be compensated for up to six hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service during a 12-month period without prior approval by the Department.



## 21. Individual-Directed Goods and Services

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS/HIV	441 IAC 78.38(9) "d"
Brain injury	441 IAC 78.43(15) "d"
Elderly	441 IAC 78.37(16) "d"
Health and disability	441 IAC 78.34(13) "d"
Intellectual disability	441 IAC 78.41(15) "d"
Physical disability	441 IAC 78.46(6) "d"

Covered individual directed goods and services are services, equipment or supplies that meet the following requirements:

- ◆ The item or service addresses an assessed need or goal identified in the member's service plan.
- ◆ The item or service is not otherwise provided through the Medicaid program and is not available through another source.
- ◆ The item or service is provided to the member or is directed exclusively toward the benefit of the member.
- ◆ The item or service can be accommodated within the member's budget without compromising the member's health and safety.
- ◆ The item or service increases the member's independence or substitutes for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
- ◆ The item or service promotes opportunities for community living and inclusion.
- ◆ The item or service is the least costly to meet the member's needs.

These items or services would primarily be purchased from a community business.

The following are examples of services, equipment or supplies that a member may purchase under individual-directed services and supports:

- ◆ Appliances that promote or enhance independence such as shower chairs, dressing devices, special toothbrush, etc.
- ◆ Assistive devices such as a microwave oven or special utensils for meals.
- ◆ Bus passes, taxi fare, or other transportation services.



- ◆ Chore services or handyman services, including heavy cleaning, snow removal, and lawn care.
- ◆ Cleaning services from firms or individuals.
- ◆ Cooking services or delivery of prepared foods.
- ◆ Employee advertising and background checks for potential employees.
- ◆ Errand services to assist with banking, shopping or other types of routine tasks, or gas money to have a friend pick up groceries.
- ◆ Home modifications such as ramps and grab bars and installation of visual or tactile alarms or wander alarms.
- ◆ Laundry services from a laundromat or cleaners.
- ◆ Medical equipment not covered by the Medicaid state plan.
- ◆ Training that enables the member's employees to deliver services with high levels of quality. Training may be purchased from a variety of sources.
- ◆ Vehicle modifications.

### **Excluded Services**

Costs of the following items and services shall **not** be covered by the individual budget:

- ◆ Childcare services
- ◆ Clothing not related to an assessed medical need
- ◆ Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue
- ◆ Costs associated with shipping items to the member
- ◆ Experimental and non-FDA-approved medications, therapies, or treatments
- ◆ Goods or services covered by other Medicaid programs
- ◆ Home furnishings such as comforters, linens, or drapes
- ◆ Home repairs or home maintenance
- ◆ Homeopathic treatments
- ◆ Insurance premiums or copayments of any kind, including home insurance, vehicle insurance, etc.
- ◆ Items purchased on installment payments



- ◆ Motorized vehicles
- ◆ Nutritional supplements such as vitamins or herbal supplements
- ◆ Personal entertainment items
- ◆ Repairs and maintenance of motor vehicles
- ◆ Room and board, including rent or mortgage payments
- ◆ School tuition
- ◆ Service animals
- ◆ Services covered by third parties or services that are the responsibility of a non-Medicaid program
- ◆ Sheltered workshop services
- ◆ Social or recreational purchases not related to an assessed need or goal identified in the member’s service plan
- ◆ Vacation expenses, other than the costs of approved services the member needs while on vacation

## 22. In-Home Family Therapy Services

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Children’s mental health	441 IAC 78.52(4)

In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships.

The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

The goal of in-home family therapy is to maintain a cohesive family unit. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through other funding sources.



### 23. Interim Medical Monitoring and Treatment

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Brain injury	441 IAC 78.43(14)
Health and disability	441 IAC 78.34(8)
Intellectual disability	441 IAC 78.41(9)

Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers.

These services:

- ◆ Provide experiences for each member’s social, emotional, intellectual, and physical development.
- ◆ Include developmental care and any special services for a member with special needs.
- ◆ Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.
- ◆ May include supervision during transportation to and from school if not available through other sources.
- ◆ Services may not duplicate any regular Medicaid or waiver services provided under the state plan. They may be provided only:
  - In the member’s home,
  - In a registered child development home,
  - In a licensed childcare center, or
  - During transportation to and from school.

Services can be used only during the following circumstances for the usual caregiver:

- ◆ Employment
- ◆ Search for employment
- ◆ Academic or vocational training
- ◆ Hospitalization for physical or mental illness
- ◆ Death

When the usual caregiver is experiencing physical or mental illness, document in the case file whether the usual caregiver is unable to care for the child. Base this determination on the usual caregiver’s plan of care and on the risk factors to the member if the parent were supervising the member during this time.



The staff-to-member ratio shall not be less than one to six. A maximum of 12 hours of service is available per day.

## 24. Mental Health Outreach

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Elderly	441 IAC 78.37(10)

Mental health outreach services are services provided in a member’s home to identify, evaluate, and provide treatment and psychosocial support. The services can be provided only based on a referral from the member’s interdisciplinary team. State plan mental health services must be accessed prior to accessing Mental Health Outreach.

## 25. Nursing Care

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 78.38(4)
Elderly	441 IAC 78.37(5)
Health and disability	441 IAC 78.34(4)
Intellectual disability	441 IAC 78.41(5)

Nursing care services are services provided by licensed agency nurses to members in the home that are ordered by and included in the plan of treatment established by the physician.

The services must be reasonable and necessary to the treatment of an illness or injury. Services should be based on medical necessity of the member and included in the Iowa Board of Nursing scope of practice guidelines. Providers must be home health agencies certified under Medicare. “Intermittent” nursing services are available under the state Medicaid plan when services are medically necessary.

NOTE: The maximums of Nursing services included in the Home Health Agency program; or Private Duty Nursing (PDN) through the EPSDT Care for Kids program must be utilized before accessing Nursing included in the HCBS Waiver programs

The defined duration of a visit/encounter is zero (0) to two (2) hours.



**Service Limitations**

- ◆ **AIDS/HIV** and **HD**. There is no limit on the maximum visits for members at the skilled level of care.
- ◆ **Elderly**. A maximum of eight nursing visits per month can be provided for members at the intermediate level of care. There is no limit on the maximum visits for members at the skilled level of care.
- ◆ **ID**. A maximum of 10 hours of service per week is covered.

<b>HCBS Waiver Service</b>	<b>Waiver Program(s)</b>	<b>Procedure Code</b>	<b>Unit of Service</b>	<b>Maximum Units</b>
Nursing (RN)	AIDS/HIV Elderly HD	T1030	Per Visit	As medically necessary and within the monthly cap for the AIDS/HIV and HD Waivers.
Nursing (LPN)	AIDS/HIV Elderly HD	T1031	Per Visit	As medically necessary and within the monthly cap for the AIDS/HIV and HD Waivers.
Nursing (RN)	ID	S9123	Per Hour	As medically necessary
Nursing (RN)	ID	S9124	Per Hour	As medically necessary

**26. Nutritional Counseling**

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Elderly	441 IAC 78.37(12)
Health and disability	441 IAC 78.34(12)

Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.



## 27. Personal Emergency Response System or Portable Locator System

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Brain injury	441 IAC 78.43(6)
Elderly	441 IAC 78.37(2)
Health and disability	441 IAC 78.34(10)
Intellectual disability	441 IAC 78.41(3)
Physical disability	441 IAC 78.46(3)

The personal emergency response system allows a member experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

- ◆ An in-home medical communication transceiver.
- ◆ A remote, portable activator.
- ◆ A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week: and
- ◆ Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently.

The member must be unable to access assistance in an emergency due to the member's age or disability. The required components of the portable locator system shall be identified in the member's service plan. Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees. Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.



## 28. Prevocational Services

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 78.43(11)
Intellectual disability	441 IAC 78.41(13)

“**Prevocational services**” means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

Prevocational services are provided to members who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include, but are not limited to:

- ◆ The ability to communicate effectively with supervisors, coworkers, and customers,
- ◆ An understanding of generally accepted community workplace conduct and dress,
- ◆ The ability to follow directions,
- ◆ The ability to attend to tasks,
- ◆ Workplace problem-solving skills and strategies,
- ◆ General workplace safety and mobility training,
- ◆ The ability to navigate local transportation options,
- ◆ Financial literacy skills, and
- ◆ Skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.



Participation in prevocational services is not a required prerequisite for individual or small-group supported employment services provided under the waiver. Many members, particularly those transitioning from school to adult activities, are likely to choose to go directly into supported employment. Similarly, the evidence-based Individual Placement and Support (IPS) model of supported employment for members with behavioral health conditions emphasizes rapid job placement in lieu of prevocational services.

The distinction between vocational and prevocational services is that prevocational services, regardless of setting, are delivered for the purpose of furthering habilitation goals that will lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage. These goals are described in the member's person-centered services and supports plan and are designed to teach skills that will lead to integrated competitive employment.

A member receiving prevocational services may pursue employment opportunities at any time to enter the general work force. Prevocational services are intended to assist members to enter the general workforce.

Members participating in prevocational services may be compensated for work performed in accordance with applicable federal laws and regulations. If a provider chooses to compensate a member for such work, the provider must use non-Medicaid funding such as revenues from a third-party contract to pay the member. The provider of prevocational services must be able to document the funding source of the member's wages from work performed. The optimal outcome of the provision of prevocational services is permanent integrated employment at or above the minimum wage in the community.

All prevocational and supported employment service options should be reviewed and considered as a component of a member's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the member. These services and supports should be designed to support successful employment outcomes consistent with the member's goals.

Personal care and assistance may be a component of prevocational services but may not comprise the entirety of the service.

Members who receive prevocational services may also receive educational, supported employment, and day habilitation services. A member's person-centered services and supports plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.

Prevocational services may include volunteer work, such as learning and training activities that prepare a member for entry into the paid workforce.

Prevocational services may be furnished to any member who requires and chooses them through a person-centered planning process.

#### **a. Career Exploration**

Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially-based informed choice regarding the goal of individual employment.

Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include:

- ◆ Business tours
- ◆ Attending industry education events
- ◆ Benefit information
- ◆ Financial literacy classes
- ◆ Attending career fairs

Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include, but is not limited to, the following activities:

- ◆ Meeting with the member and the member's family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences,
- ◆ Business tours,
- ◆ Informational interviews,
- ◆ Job shadows,
- ◆ Benefits education and financial literacy,
- ◆ Assistive technology assessment, and
- ◆ Job exploration events.



**b. Expected Outcome of Service**

The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

**c. Setting**

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

**d. Concurrent Services**

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

#### **e. Exclusions**

Prevocational services payment shall not be made for the following:

- ◆ Services that are available to the member 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 member for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

- ◆ Services available to the member that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- ◆ Compensation to members for participating in prevocational services.
- ◆ Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.
- ◆ The provision of vocational services delivered in facility-based settings where members 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.
- ◆ A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the member in continuing prevocational services or any employment situation similar to sheltered employment.

#### **f. Limitations**

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

- ◆ The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or



- ◆ The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa Vocational Rehabilitation Services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or
- ◆ The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or
- ◆ The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or
- ◆ The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or
- ◆ The member is participating in career exploration activities.

For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan. This time limit may be extended if one of the six listed criteria applies. If the criteria do not apply, the member will not be authorized to continue in prevocational services.



**g. Unit of Service**

Prevocational services are an hourly unit of service. Career exploration is an hourly unit of service

Prevocational Services: T2015: Hourly unit of service

Career Exploration: T2015 U3: Hourly unit of service

The current HCBS Prevocational and Supported Employment fee schedule may be located at:

<http://dhs.iowa.gov/ime/providers/csrp/fee-schedule>

**29. Residential-Based Supported Community Living Services**

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Intellectual disability	441 IAC 78.41(10)

Residential-based supported community living services (RBSCL) are medical or remedial services provided to children under the age of 18 while living outside their family home. The residential-based living environment is furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

Allowable service components are the following:

- ◆ **Daily living skills development.** These services develop the child’s ability to function independently in the community on a daily basis, including:
  - Training in food preparation,
  - Maintenance of living environment,
  - Time and money management,
  - Personal hygiene, and
  - Self-care.
- ◆ **Social skills development.** These services develop a child’s communication and socialization skills, including:
  - Interventions to develop a child’s ability to solve problems,
  - Resolve conflicts,
  - Develop appropriate relationships with others, and
  - Develop techniques for controlling behavior.



- ◆ **Family support development.** These services are necessary to allow a child to return to the child’s family or another less restrictive service environment.  
These services must include counseling and therapy sessions that:
  - Involve the child with the child’s family at least 50 percent of the time, and
  - Focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.
- ◆ **Counseling and behavior intervention services.** These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child’s stability. Activities under this service component may include counseling and behavior interventions with the child, including interventions to ameliorate problem behaviors.

RBSCL must provide for the ordinary daily-living needs of the child, such as needs for safety and security, social functioning, and other medical care.

RBSCL does not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid. Room and board costs are not reimbursable as RBSCL.

The maximum number of units of RBSCL available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.



### 30. Respite Care

#### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS/HIV	441 IAC 78.38(5)
Brain injury	441 IAC 78.43(3)
Children’s mental health	441 IAC 78.52(5)
Elderly	441 IAC 78.37(6)
Health and disability	441 IAC 78.34(5)
Intellectual disability	441 IAC 78.41(2)

Respite care services are services provided to the member that give temporary relief to the usual caregivers and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable members to remain in their current living situation.

Respite care is not to be provided to members during the hours in which the usual caregiver is employed or traveling to and from employment except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider or an employee paid through the Consumer Choices Option for the member.

Respite services that are not provided in a facility are divided into three types.

These types have separate rates of payment based on staff-to-member ratios and member needs, as follows:

- ◆ **Basic individual respite** is respite provided on a ratio of one staff-to-one member. The member does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.
- ◆ **Group respite** is respite provided on a ratio of one staff-to-two or more members receiving respite. These members do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.
- ◆ **Specialized respite** means respite provided on a staff-to-member ratio of one-to-one or higher to members with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.



The interdisciplinary team shall determine if the member will receive basic individual respite, group respite, or specialized respite as appropriate to the individual needs of the member.

Respite provided outside the member’s home, or the facility covered by the licensure, certification, accreditation, or contract must:

- ◆ Be approved by the parent, guardian, or primary caregiver and the interdisciplinary team.
- ◆ Be consistent with the way the location is used by the public.
- ◆ Not exceed 72 continuous hours.

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

Services provided outside the member’s home are not reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

Under the **ID** waiver, payment for respite services shall not exceed upper annual maximums provided in 441 IAC 79.1(2) per the member’s waiver year. Following is an example of how to amend the IOWANS service plan to change respite. Member S has been authorized for \$7,262 worth of respite dollars from January 1, 2014, to December 31, 2015. Member S has not used all these dollars. Now Member S wants to go to respite camp in June, and Member S also needs respite through another provider to finish Member S’s waiver year. Member S needs \$4,000 to do this.

On June 1, 2014, the worker must reduce the dollars that were used from the first period to \$3,191, providing this amount was used during the first period. The worker must contact the ISIS Help Desk to change this amount. The total amount of the respite cannot exceed the annual maximum for the ID waiver.

### 31. Self-Directed Community Supports and Employment

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 78.38(9) "d" (2)
Brain injury	441 IAC 78.43(15) "d" (2)
Elderly	441 IAC 78.37(16) "d" (2)
Health and disability	441 IAC 78.34(13) "d" (2)
Intellectual disability	441 IAC 78.41(15) "d" (2)
Physical disability	441 IAC 78.46(6) "d" (2)

Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. The following are examples of supports a member can purchase to help the member live and work in the community:

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

See [Excluded Services](#) for a list of items that may **not** be purchased as self-directed community supports and employment.

These supports are provided primarily by a member's employee. Members may purchase self-directed community supports and employment from:

- ◆ A business providing community supports and employment that has:
  - All the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
  - Current liability and workers' compensation coverage, as required by law.
- ◆ An individual, including a friend or family member, who has all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

All personnel providing self-directed community supports and employment shall:

- ◆ Be at least 18 years of age.
- ◆ Be able to communicate successfully with the member.
- ◆ Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- ◆ Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
- ◆ Not be the parent or stepparent of a minor child member or the spouse of a member.

Rates and units of services are determined through negotiation between the member and the service provider as allowed within the individual budget. The provider of self-directed community supports, and employment shall do the following:

- ◆ Specify the responsibilities of the employee and the member. Complete form [470-4427, Employment Agreement](#), with the member. The form shall be completed before the services begin and again if there are any changes.
- ◆ Establish payment arrangements with the member and the designated financial institution, and complete form [470-4428, Financial Management Service Agreement](#).



- ◆ Document the services provided and the time and days when services were provided. Prepare form [470-4429, Consumer Choices Option Semi-Monthly Time Sheet](#), and have it approved by the member. Documentation must detail the amount, duration, and scope of services provided.
- ◆ Submit the approved form 470-4429 to the financial management service within 30 days from the date when the service was provided.

### 32. Self-Directed Personal Care

#### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS/HIV	441 IAC 78.38(9) "d" (1)
Brain injury	441 IAC 78.43(15) "d" (1)
Elderly	441 IAC 78.37(16) "d" (1)
Health and disability	441 IAC 78.34(13) "d" (1)
Intellectual disability	441 IAC 78.41(15) "d" (1)
Physical disability	441 IAC 78.46(6) "d" (1)

Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. The following are examples of services that a member may hire under self-directed personal care:

- ◆ Assistance with mobility transfers, dressing, personal grooming, and showering or bathing
- ◆ Companionship, supervision, and respite care
- ◆ Homemaking tasks, such as maintenance cleaning, laundry, meal preparation, and shopping
- ◆ Medication management
- ◆ Transportation

See [Excluded Services](#) for a list of items that may not be purchased as self-directed personal care services.

The member may purchase self-directed personal care services from:

- ◆ A business that has:
  - Current liability and workers' compensation coverage.
  - All the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
- ◆ An individual, including a friend or family member, who has all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

All personnel providing self-directed personal care services shall:

- ◆ Be at least 16 years of age.
- ◆ Be able to communicate successfully with the member.
- ◆ Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- ◆ Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
- ◆ Not be the parent or stepparent of a minor child member or the spouse of a member.

Rates and units of services are determined through negotiation between the member and the service provider as allowed within the individual budget. The provider of self-directed community supports, and employment shall do the following:

- ◆ Specify the responsibilities of the employee and the member. Complete form [470-4427, \*Employment Agreement\*](#), with the member. The form shall be completed before the services begin and again if there are any changes.
- ◆ Establish payment arrangements with the member and the designated financial institution, and complete form [470-4428, \*Financial Management Service Agreement\*](#).
- ◆ Document the services provided and the time and days when services were provided. Prepare form [470-4429, \*Consumer Choices Option Semi-Monthly Time Sheet\*](#), and have it approved by the member. Documentation must detail the amount, duration, and scope of services provided.
- ◆ Submit the approved form 470-4429 to the financial management service within 30 days from the date when the service was provided.

### 33. Senior Companion Services

**Legal reference:**

Waiver Type	Corresponding Iowa Administrative Code
Elderly	441 IAC 78.37(14)

Senior companion services include nonmedical care supervision, oversight, and respite services. Companions may assist with such tasks as meal preparation, laundry, shopping, and light housekeeping tasks. This service cannot provide hands-on nursing or medical care.

### 34. Specialized Medical Equipment

**Legal reference:**

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 78.43(8)
Physical disability	441 IAC 78.46(4)

Specialized medical equipment shall include medically necessary items for personal use by a member that provide for the member’s health and safety, such as:

- ◆ Electronic aids and organizers
- ◆ Medicine dispensing devices
- ◆ Communication devices
- ◆ Bath aids
- ◆ Environmental control units
- ◆ Repair and maintenance of items purchased through the waiver

Specialized medical equipment can be covered when it is:

- ◆ Identified in the member’s approved service plan documented in IoWANS.
- ◆ Not ordinarily covered by Medicaid.
- ◆ Not funded by educational or vocational rehabilitation programs.
- ◆ Not provided by voluntary means.
- ◆ Necessary for the member’s health and safety, as documented by a health care professional.

**NOTE:** Members may receive specialized medical equipment for a maximum yearly usage as defined in 441 IAC 79.1(2).



### 35. Supported Community Living Services

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Brain injury	441 IAC 78.43(2)
Intellectual disability	441 IAC 78.41(1)

Supported community living (SCL) services are provided within the member’s home and community, according to the individualized member’s needs as identified in the approved service plan.

Services are individualized supportive services provided in a variety of community-based, integrated settings. Members may live in the home of their family or legal representative or in other types of typical community living arrangements. Members may not live in licensed medical facilities.

SCL services are intended to provide for the daily living needs of the member and shall be available on an as needed basis up to 24 hours per day. These services must:

- ◆ Be provided in the least restrictive environment possible, and
- ◆ Reflect the member’s choice of living arrangement and services.

Along with the interdisciplinary team, the case manager will identify the member’s need for service, based on the member’s needs and desires, as well as the availability and appropriateness of services.

The following criteria are used for the initial and ongoing assessments:

- ◆ Members aged 17 or under shall receive services based on development of adaptive, behavioral, or health skills.
- ◆ Service plans for members aged 20 or under must be developed or reviewed after the individual education plan (IEP) and Care for Kids (EPSDT) plan (if applicable) are developed, so as not to replace or duplicate services covered by those plans.
- ◆ Service plans for members aged 20 or under which include SCL services beyond intermittent (52 hours) will not be approved until a home health provider has made a request to cover the service through EPSDT and receives a determination of whether EPSDT is appropriate.

The case manager must attach a written request for a variance from the maximum for intermittent SCL with a summary of services and service costs.



The request must provide a rationale for requesting service beyond intermittent. The rationale must contain sufficient information for designee of the Bureau of Medical and Long-Term Services and Supports to make a decision regarding the need for SCL beyond intermittent.

Service plans must reflect all appropriate non-waiver Medicaid services so as not to duplicate or replace these services. Services shall not be simultaneously reimbursed with other residential services, waiver respite, or Medicaid or waiver nursing or home health aide services.

Services are available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure. A daily rate is applicable when a member has a need for 8 hours or more hours of SCL service per day as averaged over 30 days. This service shall provide supervision or structure in identified periods when another resource is not available.

Services are available at a 15-minute unit rate to members for whom a daily rate is not established. Intermittent service shall be provided from one to three hours a day for no more than four days a week.

Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member.

Maintenance and room and board costs are not reimbursable.

The specific support needs must be identified in the member's service plan. The total costs of SCL services shall not exceed \$1,570 per member per year. The provider must maintain records to support the expenditures.

Providers serving members for whom a daily rate is established may allocate up to \$1,570 per year for member specific support needs. The member specific support needs must be identified in the member's service plan.

- ◆ Line 3290 – Other Related Transportation. (Transportation when member is in the vehicle for service plan activities) The cost of transportation to and from medical appointments cannot be included in a provider's SCL rate.



- ◆ Line 3520 – Other Consultation/Instruction. (Expenses related to the implementation of specific service plan goals) Staff expenses can only be used to cover staff admission to activities when there are neither member nor community resources available, and there is an instructional goal for the member.
- ◆ Line 4320 – Other Equipment Repair or Purchase. (The CM is also reviewing and verifying the staffing schedule for the member on page 2 of the individual D-4. The provider must maintain records to support the expenditures.

**EXAMPLE:** \$1,570 Specific Support Needs Limit Documentation

Transportation will be provided to allow Helen to access leisure activities in her community. This will include staff mileage and bus fare. Projected costs of \$800 a year for member specific transportation. (Used to support line 3290)

Instructional money of up to \$60 will be used to purchase cookbooks needed for Helen to achieve her personal outcome and goal of learning to cook nutritious meals. (Used to support line 3520)

The maximum numbers of units of SCL available per member are as follows:

- ◆ BI or ID Waiver: 365 daily units per state fiscal year, except a leap year, when 366 daily units are available.
- ◆ ID Waiver: 20,440 15-minute units per state fiscal year, except a leap year, when 20,496 15-minute units are available.
- ◆ BI Waiver: 33,580 15-minute units per state fiscal year except a leap year when 33,672 15-minute units are available.

**a. Service Components**

The basic components of SCL service may include but are not limited to:

- ◆ **Personal and home skill training services** are those activities, which assist a member to develop or maintain skills for self-care, self-directness, and care of the immediate environment.
- ◆ **Individual advocacy service** is the act or process of representing a person’s rights and interests in order to realize the rights to which the person is entitled and to remove barriers to meeting the person’s needs.



- ◆ **Community skills training services** are activities that assist a person to develop or maintain skills and allow better participation in the community. Services must focus on the following areas as they are applicable to the person being served:
  - **Personal management skills training services** are activities that assist a member to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one’s personal business and property. This includes self-advocacy skills.

Examples of personal management skills include the ability to maintain a household budget, plan and prepare nutritional meals, use community resources (such as public transportation and libraries), and select foods at the grocery store.
  - **Socialization skills training services** are activities, which assist a member to develop or maintain skills, which include self-awareness and self-control, social responsiveness, group participation, social amenities, and interpersonal skills.
  - **Communication skills training services** are activities that assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.
- ◆ **Personal environment support services** are activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.
- ◆ **Transportation services** are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life’s activities. Transportation cannot include costs to provide transportation to and from medical appointments funded through the state plan non-emergency medical transportation (NEMT) service. For the ID Waiver the cost of all transportation, excluding NEMT, is included in the daily SCL tiered rate reimbursement.

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

Allowable service activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management, or other case management.

SCL provided to adults (18 years of age and older) may include support and supervision as part of SCL services regardless of whether the reimbursement is for daily or 15-minute unit SCL.

Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability or brain injury waivers.

**b. Living Arrangements**

A member may choose to live in a variety of living environments. A member may live alone, or with family, friends, other members, or staff. A member may buy or rent a house, trailer, condominium, or an apartment. A member may live in an environment owned by the member, by an agency, or by someone else. A maximum of four persons may reside in a living unit.

Group living units serving five persons must be pre-approved by the Department. Living units serving more than five members must be licensed as a residential care facility. Living units must be located at scattered sites throughout the community, with regard for community norms in geographical proximity of residences.

Members under the age of 18 living outside of the family home must live in a licensed environment.

All residential settings when members receiving HCBS waiver services must meet the following federally established criteria:

- ◆ The setting is integrated in, and facilitates the member's full access to, the greater community, including:
  - Opportunities to seek employment and work in competitive integrated settings,
  - Engage in community life,
  - Control personal resources, and
  - Receive services in the community, like individuals without disabilities.
- ◆ The setting is selected by the member among all available alternatives and identified in the person-centered service plan.
- ◆ A member's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected.
- ◆ Individual initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented; and
- ◆ Individual choice regarding services and supports, and who provides them, is facilitated.

If the residential setting is a provider-owned or controlled residential setting, the following conditions apply:

- ◆ Any modifications of the conditions (for example to address the safety needs of a member with dementia) must be supported by a specific assessed need and documented in the person-centered service plan.



- ◆ The unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord and tenant laws of the state, county, city, or other designated entity.
- ◆ Each member has privacy in the member’s sleeping or living unit.
- ◆ Units have lockable entrance doors, with appropriate staff having keys to doors.
- ◆ Members share units only at the member’s choice.
- ◆ Members have the freedom to furnish and decorate their sleeping or living units.
- ◆ Members have the freedom and support to control their own schedules and activities and have access to food at any time.
- ◆ Members are able to have visitors of their choosing at any time.
- ◆ The setting is physically accessible to the member.



### **36. Supported Employment Services**

#### **Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Brain injury	441 IAC 78.43(4)
Intellectual disability	441 IAC 78.41(7)

#### **a. Supported Employment – Individual Supported Employment**

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

Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

##### **(1) Expected Outcome of Service**

The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

##### **(2) Setting**

Individual supported employment services shall take place in integrated work settings.

For self-employment, the member’s home can be considered an integrated work setting. Employment in the service provider’s organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work

setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

Individual employment strategies include, but are not limited to:

- ◆ Customized employment,
- ◆ Individual placement and support, and
- ◆ Supported self-employment.

Service activities are individualized and may include any combination of the following:

- ◆ Benefits education
- ◆ Career exploration (e.g., tours, informational interviews, job shadows)
- ◆ Employment assessment
- ◆ Assistive technology assessment
- ◆ Trial work experience
- ◆ Person-centered employment planning
- ◆ Development of visual or traditional résumés
- ◆ Job-seeking skills training and support
- ◆ Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis)
- ◆ Job analysis (e.g., work site assessment or job accommodations evaluation)
- ◆ Identifying and arranging transportation
- ◆ Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer)
- ◆ Reemployment services (if necessary due to job loss)
- ◆ Financial literacy and asset development
- ◆ Other employment support services deemed necessary to enable the member to obtain employment



- ◆ Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization
- ◆ Engagement of natural supports during initial period of employment
- ◆ Implementation of assistive technology solutions during initial period of employment
- ◆ Transportation of the member during service hours
- ◆ Initial on-the-job training to stabilization activity

**b. Supported Self-Employment**

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

An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under Individual Supported Employment, assistance to establish self-employment may include:

- ◆ Aid to the member in identifying potential business opportunities.
- ◆ Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
- ◆ Identification of the long-term supports necessary for the individual to operate the business.

**(1) Long-Term Job Coaching**

Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

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

## **(2) Expected Outcome of Service**

The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals.

An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

## **(3) Setting**

Long-term job coaching services shall take place in integrated work settings.

For self-employment, the member's home can be considered an integrated work setting.

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

## **(4) Service Activities**

Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

- ◆ Job analysis
- ◆ Job training and systematic instruction
- ◆ Training and support for use of assistive technology and adaptive aids



- ◆ Engagement of natural supports
- ◆ Transportation coordination
- ◆ Job retention training and support
- ◆ Benefits education and ongoing support
- ◆ Supports for career advancement
- ◆ Financial literacy and asset development
- ◆ Employer consultation and support
- ◆ Negotiation with employer on behalf of the member (e.g., accommodations, employment conditions, access to natural supports, and wage and benefits)
- ◆ Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting
- ◆ Transportation of the member during service hours
- ◆ Career exploration services leading to increased hours or career advancement

#### **(5) Self-Employment Long-Term Job Coaching**

Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment.

In addition to the activities listed under 441 IAC 78.27(10) "b" (4), assistance to maintain self-employment may include:

- ◆ Ongoing identification of the supports necessary for the individual to operate the business.
- ◆ Ongoing assistance, counseling and guidance to maintain and grow the business; and
- ◆ Ongoing benefits education and support.

## (6) Units of Service

Long-term job coaching services are based on the identified needs of the member as documented in the member’s comprehensive service plan. The member is authorized for a monthly tier of service based on the number of hours of direct support and activities on behalf of the member that the member requires each month to maintain their employment.

<b>Long Term Job Coaching Tiers</b>		
Tier 1	1 contact/month, monthly unit of service	H2025 U4
Tier 2	2-8 hours/month, monthly unit of service	H2025 U3
Tier 3	9-16 hours/month, monthly unit of service	H2025 U5
Tier 4	17-25 hours/month, monthly unit of service	H2025 U7
Tier 5	26 or more hours/month, hourly unit of service	H2025 UC

Each long-term job coaching tier is billed as one monthly unit of service with the exception of Tier 5. When a member requires 26 or more hours of long-term job coaching during the month, the units of service entered into the service plan are the total number of hours of support required for the month.

The current HCBS Prevocational and Supported Employment fee schedule may be located at:

<http://dhs.iowa.gov/ime/providers/csrp/fee-schedule>

### c. **Small-Group Employment (2 to 8 Individuals)**

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

Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include, but are not limited to:

- ◆ Mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings.
- ◆ Small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

### **(1) Expected Outcome of Service**

Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment.

Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

### **(2) Setting**

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

### **(3) Service Activities**

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

- ◆ Employment assessment
- ◆ Person-centered employment planning
- ◆ Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave)



- ◆ Job analysis
- ◆ On-the-job training and systematic instruction
- ◆ Job coaching
- ◆ Transportation planning and training
- ◆ Benefits education
- ◆ Career exploration services leading to career advancement outcomes
- ◆ Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting
- ◆ Transportation of the member during service hours

#### **(4) Units of Service**

Small-group supported employment services are authorized for the number of units of service the member requires based on the number of individuals in the small group.

<b>Small-Group Employment Tiers</b>		
Tier 1	Groups of 2 to 4	H2023 U3
Tier 2	Groups of 5 or 6	H2023 U5
Tier 3	Groups of 7 or 8	H2023 U7

The current HCBS Prevocational and Supported Employment fee schedule may be located at:

<http://dhs.iowa.gov/ime/providers/csrp/fee-schedule>

#### **d. Service Requirements for All Supported Employment Services**

Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member’s interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member’s place of residence and the employment or service location may be included as a component part of supported employment services.



Personal care or personal assistance and protective oversight may be a component part of supported employment services but may not comprise the entirety of the service.

Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

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

Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

### **(1) Compensation**

Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

## **(2) Limitations**

Supported employment services are limited as follows:

- ◆ In the absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed the limit established in 441 IAC 79.1(2).
- ◆ Individual supported employment is limited to 60 units per calendar year. The member may be initially authorized for 40 units and an extended authorization for an additional 20 units as needed by the member.
- ◆ Long-term job coaching is limited to 40 hours per week and must be reauthorized every 90 days.
- ◆ Small-group supported employment is limited to 160 (15 minute) units per week.

## **(3) Exclusions**

Supported employment services payments shall not be made for the following:

- ◆ Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

- ◆ Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.
- ◆ Subsidies or payments that are passed through to users of supported employment programs.
- ◆ Training that is not directly related to a member's supported employment program.
- ◆ Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.



- ◆ 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.
- ◆ Tuition for education or vocational training.
- ◆ Individual advocacy that is not related to integrated individual employment participation or is not member-specific.
- ◆ Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

EXAMPLE: Due to his bi-polar disorder, Member B has never been employed, but he would like to work. His provider finds that Member B has an interest and aptitude for working with animals.

The provider contacts local pet stores to explain Member B's situation and arranges for a job interview for Member B. These activities would be considered job procurement training and are reimbursable as "individual supported employment" activities on behalf of the member.

The employer hires Member B to help take care of the animals. Provider staff works with Member B to assist him in learning his job duties. During the first two weeks, the provider works with Member B at the job site for an hour per day. For the next two weeks, staff assists him every other day.

Staff also makes periodic contact with the employer to check on Member B's performance and identify any trouble areas.

These activities are considered job coaching and job retention supports and would be reimbursable as "long-term job coaching."

One day, Member B becomes agitated while at work and yells at another employee. Provider staff responds by coming to the job site and assisting Member B in regaining his composure. The staff finds that Member B was confused about some of his duties and became upset when his co-worker pointed out some things Member B had not done.

Provider staff then assists Member B in communicating about the problem with the employer and co-worker and in clarifying his duties.



**e. Resource Sharing Between Iowa Medicaid and Iowa Vocational Rehabilitation Services**

People are more likely to succeed in employment when funding and services available through both IVRS and Medicaid are shared. Each program has limitations but together they can provide holistic support for someone with a disability who wants to find and keep community-integrated employment. Please refer to [Section M](#) of this manual. IVRS and Iowa Medicaid have outlined our respective funding obligations when paying for Supported Employment Services (SES) for a mutual client served by both agencies.

**f. Employment Resources for Case Managers, Care Managers, Service Coordinators, and Integrated Health Home Coordinators**

The Iowa Department of Human Services and our Employment 1st partners are committed to ensuring all people with disabilities have the opportunity to work in the general workforce, and to enjoy the many benefits that are associated with having employment.

We recognize that case managers, care managers, service coordinators, and integrated health home coordinators have a critical role to play in enabling more Iowans with disabilities to find and keep employment in the general workforce. In recognition of the critical role these professionals play, the *Iowa Employment 1st Guidebook* was created.

This Guidebook was created to provide case managers, care managers, service coordinators, and integrated health home care coordinators with critical information, resources, and tools to help them do the best possible job of assisting transition-age youth and working-age adults with disabilities they support to work.

The guidebook may be accessed online at:

[https://dhs.iowa.gov/sites/default/files/Employment\\_First\\_Guidebook\\_2016.pdf](https://dhs.iowa.gov/sites/default/files/Employment_First_Guidebook_2016.pdf)

### 37. Transportation

#### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 78.43(7)
Elderly	441 IAC 78.37(11)
Intellectual disability	441 IAC 78.41(11)
Physical disability	441 IAC 78.46(5)

Transportation services may be provided for members:

- ◆ To conduct business errands and essential shopping,
- ◆ To travel to and from work or day programs (BI, EW, ID, and PD), or
- ◆ To reduce social isolation.

HCBS waiver transportation services will be authorized and reimbursed at the HCBS transportation provider's NEMT contracted rate or the lesser of the provider's rate or the published weighted average rate paid per mile within the member's MHDS region. These published rates are considered the upper rate limit; providers may charge no more than the published rate per mile.

Transportation providers may not charge a Medicaid member more than they charge other public or private pay riders for the same service.

#### a. HCBS Transportation and Supported Community Living (SCL) Services

A provider may include the costs of transportation that are directly associated with the provision of SCL services in their reimbursement rate. Transportation is also a stand-alone service in the intellectual disability (ID) and brain injury (BI) waiver programs that provides payment for:

- ◆ Transporting a member to conduct business errands,
- ◆ Essential shopping,
- ◆ To and from work or day programs, and
- ◆ To reduce social isolation.

Transportation may not be reimbursed when HCBS ID waiver daily SCL is authorized in a member's service plan. The cost of transportation has been included in the daily SCL tiered rates. The ID waiver daily SCL service provider is responsible for the payment of needed transportation costs identified in the member's service plan.



A provider may not simultaneously bill for ID Waiver daily SCL services and transportation (the service) when the cost of transportation is included in the SCL rate paid to the provider. This would be considered double billing Medicaid for the same service.

**b. Non-Emergency Medical Transportation (NEMT) and Waiver Transportation Services**

The NEMT broker will pay for the cost of transportation and does not pay for the cost of support staff needed to transport the member to medical appointments. SCL providers may provide the staff support for medical transportation as part of the SCL service but may not include the costs of the medical transportation in the rate structure. No medical transportation costs may be included as part of the \$1,570 funds used for SCL rate development or the SCL cost reports. SCL providers may need to assist member in arranging medical transportation with the NEMT broker.

**c. Electronic Visit Verification (EVV)**

Electronic Visit Verification, or EVV, is a federal requirement for states to implement. In December 2016, the 21st Century Cures Act was signed into law. This law requires EVV for personal care and home health services.

The MCOs are contractually required to utilize EVV for Home- and Community-Based Services (HCBS), Home Health Services, Hospice and Early and Periodic Screening Diagnosis and Treatment (EPSDT) service.

EVV is used to monitor member receipt and utilization of services. EVV provides verification of a visit with a time stamp. This data is used to generate claims and serves a function similar to electronic time sheets. EVV is also used for quality and program integrity (PI).

EVV is currently required for the following service codes provided through an MCO:

- ◆ S5125 - Attendant Care Services, Per 15 Minutes
- ◆ S5130 - Homemaker NOS, Per 15 Minutes
- ◆ S5131 - Homemaker NOS, Per Diem
- ◆ T1019 - Personal Care Services, Per 15 Minutes

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EVV is optional for all personal care services provided by Assisted Living Facility (ALF) and Residential Care Facility (RCF) shift workers. ALF and RCF providers must complete an attestation identifying their exemption status annually via the provider self-assessment thereafter. Read [Informational Letter 2239-MC](#) for more details.

EVV implementation for ALF and RCF providers who use non-shift workers for personal care services are required to use EVV.

Additional information is available on the [EVV webpage](#).

## C. Provider Enrollment With Iowa Medicaid

### 1. Certification and Enrollment of New Providers

To apply for enrollment as an Iowa Medicaid enrolled provider of waiver services, contact Iowa Medicaid Provider Services by phone at (800) 338-7909 or locally in Des Moines at (515) 256-4609, or in writing at:

Iowa Medicaid Provider Service  
 PO Box 36450  
 Des Moines, IA 50315

The Iowa Medicaid Provider Services Unit provides telephone support to answer any billing questions from providers. The number is (800) 338-7909 or locally in Des Moines at (515) 256-4609.

#### Relevant Forms for enrolling as a NEW INDIVIDUAL CDAC PROVIDER:

1. [Iowa Medicaid HCBS Waiver Provider Application \(pages 5-6 only\) \(Form 470-2917\)](#)
2. [Individual CDAC Disclosure \(Form 470-4612\)](#)
3. [Provider Agreement \(Form 470-2965\)](#)
4. [W-9 Form \(IRS Tax Form W-9\)](#)
5. [Record Check Consent \(Form 470-4227\)](#)
6. [Atypical Provider Declaration \(Form 470-4457\)](#)



7. [Electronic Funds Transfer \(EFT\) \(Form 470-4202\)](#)
8. Proof of Age (e.g., copy driver’s license, birth certificate, State-issued ID, passport)

**If you are already a CDAC provider**

As an active CDAC provider, the following resources, information, and CDAC-relevant forms will help you in the administrative process when filing claims for the services that you provide to the member.

**Relevant Forms for ACTIVE CDAC PROVIDERS:**

- ◆ [HCBS Consumer Directed Attendant Care Agreement \(Form 470-3372\)](#)
- ◆ [CDAC Daily Service Record \(Form 470-4389\)](#)

If you wish to enroll as a WAIVER provider (for agencies and businesses)

Waiver providers are eligible to participate in the Iowa Medicaid Home- and Community-Based Services (HCBS) Waiver program if they meet the standards for the service to be provided. Qualifications are defined on the enrollment application. Your agency or business must meet one of the enrollment qualifications under each service for which you are enrolling.

Necessary forms for enrolling as a WAIVER PROVIDER

- ◆ Form [470-2917, Medicaid HCBS Waiver Provider Application](#), and instructions for its completion, and
- ◆ Form [470-2965, Iowa Medicaid Provider Agreement General Terms](#), and
- ◆ Form [W-9, Request for Taxpayer Identification Number and Certification](#), and
- ◆ Form [470-5112, Designated Contact Person](#), and
- ◆ Form [470-5186, Iowa Medicaid Ownership and Control Disclosure](#), and
- ◆ Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 135c.33(1) “b” before employment of a staff member who will provide direct care.
- ◆ If comprehensive preliminary background check determines that the person being considered for employment has been convicted of a crime under a law of any state, the department of public safety shall notify the facility or provider that upon the request of the facility or provider the



department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person’s employment in the facility or with the provider.

- ◆ If a person being considered for employment, other than employment involving the operation of a motor vehicle, has been convicted of a crime listed 135C.33(1) “c” (1) (a) but does not have a record of founded child or dependent adult abuse, and the facility or provider has requested an evaluation in accordance with paragraph “a” to determine whether the crime warrants prohibition of the person’s employment, the facility or provider may employ the person for not more than sixty calendar days pending completion of the evaluation.
- ◆ The department of human services has final authority in determining whether prohibition of the person’s employment is warranted

Submit the completed application to the Iowa Medicaid Provider Services address listed previously. The Iowa Medicaid must receive the application for enrollment at least 90 days before the planned implementation date.

The Iowa Medicaid Provider Services Unit will review the submitted application and any required documentation necessary to qualify as a provider of the service for which application is being made. This may include:

- ◆ Current accreditations, evaluations, inspections, and reviews by regulatory and licensing agencies and associations policies, procedures and forms.
- ◆ All providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

Deemed status is available for agencies accredited in good standing as a provider of a similar service by:

- ◆ The Council on Accreditation of Rehabilitation Facilities (CARF), or
- ◆ The Council on Accreditation of Services for Families and Children (COA), or
- ◆ The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
- ◆ The Council on Quality and Leadership in Supports for People with Disabilities (the Council).



“Similar service” means the CARF-accredited, COA-accredited, JCAHO-accredited, or Council-accredited service is provided in the least restrictive environment, promotes independence, provides consumer choice, and includes all other service elements as described in this manual for the specific service.

If seeking deemed status, submit copies of current CARF, COA, JCAHO, or Council accreditation and the evaluations which show the agency to be in good standing. “Good standing” means the accreditation is current and unconditional.

If substantial compliance with required standards at the time of the review is demonstrated and remains unconditionally accredited by CARF or the Council, deemed status for this service will continue for the duration of the national body’s accreditation period.

**NOTE:** If deemed status has been granted due to CARF or Council accreditation, but when a new CARF or Council survey is completed, the agency is not recertified for two or three years (as applicable), then the agency must notify IME regarding the change in status. HCBS specialists may complete an on-site review to determine if the agency is to remain eligible for waiver certification, based on:

- ◆ The fiscal capacity to initiate and operate the specified programs on an ongoing basis.
- ◆ A written agreement to work cooperatively with the state and the counties that will be served. This is requested of those applying for all certified services and is not specific to deemed status.

The Provider Services Unit has 60 days from the receipt of all required documentation and completed background checks for individual CDAC to determine whether the provider meets the applicable standards for providing waiver services. (This deadline may be extended by mutual consent.)

When an application is approved, Provider Services will recommend enrollment. Review of a provider may occur at any time that it is determined to be necessary.



## 2. Adding a New Service for Existing Provider

A new application is required to add a new waiver service to an existing waiver provider. Access form [470-2917, Medicaid HCBS Waiver Provider Application](#), online or contact the Iowa Medicaid Provider Services Unit at (800) 338-7909, or locally in Des Moines at (515) 256-4609 for an application to be mailed. When completing the new application, attach documentation necessary to qualify as a provider of the service.

## 3. Changes

The Provider Services Unit must be notified when:

- ◆ Enrollment is not renewed.
- ◆ The provision of any waiver service is withdrawn.
- ◆ A new service under a specific waiver is added.

Notice must be in writing and must be received by the Provider Services Unit 30 days before the date of service or program termination.

## 4. Change in Ownership, Agency Name, or Satellite Offices

If the ownership or name change does not involve the issuance of a new federal tax identification number, the agency is not required to complete a new *Medicaid HCBS Waiver Provider Application*, form 470-2917.

Adding a satellite office does not require the completion of a new waiver provider application if the satellite office uses the main office's provider number for billing purposes. If the agency chooses to have a separate provider number for the satellite office, it must submit another waiver application for that new satellite office.

## 5. Recertification

The agency must be recertified when its current certification ends. The agency must demonstrate substantial continued compliance with standards for recertification to occur. The HCBS specialist initiates recertification.



The recertification procedures for supported community living, supported employment, behavioral programming, and certified respite services are initiated:

- ◆ Before the expiration of the current certification, and
- ◆ To determine compliance with Iowa Administrative Code service standards or determination that the agency remains accredited by a recognized national accrediting body.

## 6. Deemed Status Providers

If the agency is accredited for similar services, its certification continues as long as it maintains current accreditation as outlined in [Certification and Enrollment of New Providers](#). Submit reports from the accrediting body to the HCBS specialist as documentation of continued accreditation. The HCBS specialists may conduct an on-site review to evaluate compliance with required standards.

## 7. Certified Providers

If the agency is certified without deemed status, specialists will conduct an on-site review in conjunction with the HCBS quality management activities.

The HCBS specialists will look at member files, personnel records, and the organization's implementation of policies and procedures to ensure that the service has the greatest impact on members and provides opportunities to improve service outcomes. The HCBS specialists will hold an exit conference with the agency to share preliminary findings of the review.

Following the review, HCBS specialists will issue a review report, noting service strengths and deficiencies, within 30 business days unless the agency and the specialist mutually agree to extend that time frame. A provider acknowledgement identifying that the agency has received the review report and will actively work to correct the areas noted in the report is required.

Corrective action plans are required when the necessary criteria are not met. The corrective action plans will be monitored to ensure their implementation. The specialist will determine if this monitoring will be done through the submission of written reports or as an on-site review.



## D. Standards for Providers of Service

Providers are eligible to participate in the Medicaid program as approved waiver service providers based on the standards pertaining to the individual service.

In order to provide quality services to members, organizations need to have sound administrative and organizational practices. Providers should have a core set of policies and procedures based on the services for which they are enrolled to provide. The policies and procedures are the foundation of a provider's performance and guide them on the provision of services. The organization must have written policies and procedures that outline the organization's day-to-day operations, ensure compliance with laws and regulations, and give guidance for staff.

At a minimum, HCBS Waiver Providers must have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge, and referral. "Service coordination" means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community. This is specific to certified services.

Providers must also have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the Department.

Providers and their staff must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before the provision of direct care services to members of any waiver program.

Providers and contracting entities are required to check the program exclusion status of individuals and entities before entering into employment or contractual relationships. To determine whether an individual or entity is excluded, search the HHS-OIG website at: <http://exclusions.oig.hhs.gov/>.

An excluded individual or an entity employing or contracting with an excluded individual or entity that submits a claim for reimbursement to a federal health care program, or causes such a claim to be submitted, may be subject to civil money penalties and other damages for each item or service furnished during the period that the person or entity was excluded (section 1128A(a)(1)(D) of the Social Security Act).



Providers should search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search. Claims paid by the Medicaid program for services rendered by an excluded individual or entity are subject to repayment. Providers may also be subject to penalties by the OIG. Providers can search the HHS-OIG website by the name of any individual or entity. An additional listing of parties excluded from any federal payment is the System for Award Management (SAM) at: <https://www.sam.gov>. It is recommended that this listing be checked as well.

Enrollment carries no assurance that the approved provider will receive funding. Payment for services will be made to a provider only upon Department approval of the provider and of the service the provider is authorized to provide on an individual member basis.

Iowa Medicaid shall review compliance with standards for initial enrollment. Review of a provider may occur at any time.

The Department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This information may include:

- ◆ Current accreditations.
- ◆ Evaluations.
- ◆ Inspection reports.
- ◆ Reviews by regulatory and licensing agencies and associations.
- ◆ Evidence of financial sustainability.

All Medicaid providers are expected to adhere to the state and federal rules applicable to each service and business operation including the Department of Labor, Fair Labor Standards Act.

### **1. Home- and Community-Based Services (HCBS) Provider Quality Management Self-Assessment**

The Home- and Community-Based Services (HCBS) Provider Quality Management Self-Assessment process was developed as a way for the state to gather data to support the quality framework performance measures as required by the Centers for Medicare and Medicaid Services (CMS). The provider self-assessment process mirrors a CMS review process by requiring HCBS waiver providers to develop a quality improvement system of monitoring their own performance and then "showing" the state how it provides quality oversight.

The first step in the provider self-assessment process is to identify a core set of policies and procedures for all waiver providers based on the services they provide. The policies and procedures are the foundation of a provider's performance and guide them on the provision of HCBS waiver services. The state has identified a minimal set of policies and procedures based on the CMS assurances, Iowa Administrative Code requirements, laws found in the Iowa Code, federal regulations, and best practices identified through previous quality oversight activities of HCBS providers.

The provider self-assessment requires a provider to identify the applicable policies and procedures that have been established by the agency upon enrollment to ensure compliance with laws, rules, regulations, and best practices. A provider may also identify any of the standards in the self-assessment that are not applicable to the services for which they are enrolled.

Once the core policies and procedures have been established through the self-assessment, the HCBS Quality Oversight staff uses four methods of discovery to verify the implementation of a provider's quality performance activities:

- ◆ Annual self-assessment,
- ◆ Targeted review,
- ◆ Focused review, and
- ◆ Periodic or Certification review.

These reviews may be completed via a desk or on-site review.

The Provider Quality Management Self-Assessment reflects this process as well as information obtained from provider input. The focus of the Provider Quality Management Self-Assessment and subsequent review activities are to assist providers in regulatory compliance and quality improvement.

This system of provider oversight is required for all Medicaid providers enrolled to provide the following HCBS waiver services:

- ◆ **AIDS/HIV waiver.** Agency consumer-directed attendant care (CDAC), respite, adult day care, and counseling.
- ◆ **Brain injury waiver.** Behavior programming, agency CDAC, respite, supported community living (SCL), supported employment, prevocational, Interim Medical Monitoring and Treatment (IMMT), adult day care, family counseling, and training.



- ◆ **Children’s mental health waiver.** Family and community support services, in-home family therapy, and respite.
- ◆ **Elderly waiver.** Agency CDAC assisted living service, respite, adult day care, case management (including those that are Chapter 24 accredited), and mental health outreach.
- ◆ Health and disability waiver. Respite, agency CDAC, IMMT, adult day care, and counseling
- ◆ **Intellectual disability waiver.** Agency CDAC, respite, SCL, supported employment, prevocational, IMMT, adult day care, day habilitation, residential-based supported community living (RBSCL).
- ◆ **Physical disability waiver.** Agency CDAC.

Provider standards for each service under the HCBS waivers are listed in the following pages.

## 2. Adult Day Care Providers

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 77.34(7)
Brain injury	441 IAC 77.39(20)
Elderly	441 IAC 77.33(1)
Health and disability	441 IAC 77.30(3)
Intellectual disability	441 IAC 77.37(25)

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

## 3. Assisted Living Providers

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Elderly	441 IAC 77.33(23)

Assisted living service providers shall be assisted living programs that are certified by the Department of Inspections and Appeals under 481 IAC Chapter 69.



#### 4. Behavioral Programming Providers

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Brain injury	441 IAC 77.39(23)

Behavioral programming providers shall be required to have experience with or training regarding the special needs of members with a brain injury.

In addition, they must meet the following requirements:

- ◆ Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441 IAC 83.81(249A). Formal assessment of the member’s intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- ◆ Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441 IAC 83.81(249A) and who are employees of one of the following:
  - Agencies which are certified under the community mental health center standards established by the Mental Health and Developmental Disabilities Commission, set forth in 441 IAC 24, Divisions I and III.
  - Agencies which are licensed as meeting the hospice standards and requirements set forth in Department of Inspections and Appeals rules 481 IAC Chapter 53, or which are certified to meet the standards under the Medicare program for hospice programs.
  - Agencies which are accredited under the mental health service provider standards established by the Mental Health and Disabilities Commission, set forth in 441 IAC 24, Divisions I and IV.
  - Home health aide providers meeting the standards set forth in rule 441 IAC 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.
  - Brain injury waiver providers certified pursuant to rule 441 IAC 77.39(249A).

**NOTE:** See [Home- and Community-Based Services \(HCBS\) Provider Quality Management Self-Assessment](#) for a list of outcome-based standards that apply to the providers of behavioral management services.



## 5. Case Management Service Providers

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 77.39(12)
Elderly	441 IAC 77.33(21)

Case management provider organizations are eligible to participate in the Medicaid HCBS elderly and brain injury waiver programs provided that it:

- ◆ Is accredited by the Mental Health, Intellectual Disability, Developmental Disabilities, and Brain Injury Commission as meeting the standards for case management services in 441 IAC Chapter 24; or
- ◆ Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or
- ◆ Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or
- ◆ Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or
- ◆ Is approved by the Department on Aging as meeting the standards for case management services in 17 IAC 21; or
- ◆ Is authorized to provide similar services through a contract with the Department of Public Health (IDPH) for local public health services and that it:
  - Meets the qualifications for case managers in 641 IAC 80.6(1); and
  - A case management provider shall not provide direct services to the member. The Department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management members to be a conflict of interest. A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver members. The provider must have written conflict of interest policies that include, but are not limited to:
    - ◆ Specific procedures to identify conflicts of interest.
    - ◆ Procedures to eliminate any conflict of interest that is identified.
    - ◆ Procedures for handling complaints of conflict of interest, including written documentation.



If the case management provider organization subcontracts case management services to another entity:

- ◆ That entity must also meet the provider qualifications in this subrule, and
- ◆ The contractor is responsible for verification of compliance.

Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441 IAC Chapter 24, and they are the Department of Human Services, Mental Health and Disabilities (MHDS) region, or a provider under subcontract to the Department or an MHDS region.

## 6. Chore Service Providers

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Elderly	441 IAC 77.33(7)

The following providers may provide chore services:

- ◆ Home health agencies certified under Medicare.
- ◆ Community action agencies as designated in Iowa Code section 216A.93.
- ◆ Agencies authorized to provide similar services through a contract with the Iowa Department of Public Health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
- ◆ Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- ◆ Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.
- ◆ Community businesses that are engaged in the provision of chore services and that:
  - Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and
  - Submit verification of current liability and workers' compensation coverage, as required by law.



## 7. Consumer Choices Option Providers

Providers under the consumer choices option fall under the following categories of providers listed below.

### a. Financial Management Service

#### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS/HIV	441 IAC 77.34(9)
Brain injury	441 IAC 77.39(26)
Elderly	441 IAC 77.33(16)
Health and disability	441 IAC 77.30(13)
Intellectual disability	441 IAC 77.37(28)
Physical disability	441 IAC 77.41(7)

Members who elect the consumer choices option shall work with a Financial Management Service (FMS) provider that meets the following qualifications.

The FMS shall either:

- ◆ Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration, or by the credit union division of the Iowa Department of Commerce; or
- ◆ 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).
  - The financial institution shall complete a financial management readiness review and certification conducted by the Department or its designee.
  - The financial institution shall obtain an Internal Revenue Service federal employee identification member dedicated to the financial management service.
  - The financial institution shall enroll as a Medicaid provider.



**b. Independent Support Brokerage**

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 77.34(10)
Brain injury	441 IAC 77.39(27)
Elderly	441 IAC 77.33(17)
Health and disability	441 IAC 77.30(14)
Intellectual disability	441 IAC 77.37(29)
Physical disability	441 IAC 77.41(8)

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

- ◆ The broker must be at least 18 years of age.
- ◆ The broker shall not be the legal representative under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.
- ◆ The broker shall not provide any other paid service to the member.
- ◆ The broker shall not work for an individual or entity that is providing services to the member.
- ◆ The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
- ◆ The broker must complete an independent support brokerage training approved by the Department.

**c. Self-Directed Personal Care**

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 77.34(11)
Brain injury	441 IAC 77.39(28)
Elderly	441 IAC 77.33(18)
Health and disability	441 IAC 77.30(15)
Intellectual disability	441 IAC 77.37(30)
Physical disability	441 IAC 77.41(9)

Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business.

A business providing self-directed personal care services shall:

- ◆ Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations.
- ◆ Have current liability and workers' compensation coverage; and
- ◆ An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

All personnel providing self-directed personal care services shall:

- ◆ Be at least 16 years of age, and
- ◆ Be able to communicate successfully with the member, and
- ◆ Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services, and
- ◆ Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option, and
- ◆ Not be the parent or stepparent of a minor child member or the spouse of a member.

The provider of self-directed personal care services shall:

- ◆ Prepare timecards or invoices approved by the Department that identify what services were provided and the time when services were provided.



- ◆ Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period

**d. Individual-Directed Goods and Services**

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 77.34(12)
Brain injury	441 IAC 77.39(29)
Elderly	441 IAC 77.33(19)
Health and disability	441 IAC 77.30(16)
Intellectual disability	441 IAC 77.37(31)
Physical disability	441 IAC 77.41(10)

Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business.

A business providing individual-directed goods and services shall:

- ◆ Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulation; and
- ◆ Have current liability and workers’ compensation coverage; and
- ◆ Have all the necessary licenses required by federal, state, and local laws, including a valid driver’s license if providing transportation.

All personnel providing individual-directed goods and services shall:

- ◆ Be at least 18 years of age, and
- ◆ Be able to communicate successfully with the member, and
- ◆ Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services, and
- ◆ Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option, and
- ◆ Not be the parent or stepparent of a minor child member or the spouse of the spouse of a member.

The provider of individual-directed goods and services shall:

- ◆ Prepare timecards or invoices approved by the Department that identify what services were provided and the time when services were provided.
- ◆ Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

**e. Self-Directed Community Supports and Employment**

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 77.34(13)
Brain injury	441 IAC 77.39(30)
Elderly	441 IAC 77.33(20)
Health and disability	441 IAC 77.30(17)
Intellectual disability	441 IAC 77.37(32)
Physical disability	441 IAC 77.41(11)

Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business.

A business providing community supports and employment shall:

- ◆ Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
- ◆ Have current liability and workers' compensation coverage; and
- ◆ A person providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

All personnel providing self-directed community supports and employment shall:

- ◆ Be at least 18 years of age, and
- ◆ Be able to communicate successfully with the member, and



- ◆ Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services, and
- ◆ Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option, and
- ◆ Not be the parent or stepparent of a minor child member or the spouse of a member the spouse of a member.

The provider of self-directed community supports, and employment shall:

- ◆ Prepare time sheet or invoices approved by the Department that identify what services were provided and the time when services were provided.
- ◆ Submit invoices and time sheets to the financial management service within 30 days from the date when the service was provided.

## 8. Consumer-Directed Attendant Care Providers

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 77.34(8)
Brain injury	441 IAC 77.39(24)
Elderly	441 IAC 77.33(15)
Health and disability	441 IAC 77.30(7)
Intellectual disability	441 IAC 77.37(21)
Physical disability	441 IAC 77.41(2)

A public or private agency or an individual working independently as a provider of consumer-directed attendant care must be enrolled to provide HCBS waiver services.

The following providers may be enrolled to provide consumer-directed attendant care service:

- ◆ An individual who contracts with the member to provide attendant care service and who is:
  - At least 18 years of age.
  - Qualified by training or experience to carry out the member’s plan of care pursuant to the Department-approved service plan.



- Not the spouse of the member, or a parent or stepparent of a member aged 17 or under.
- Not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS waiver services.
- ◆ Agencies authorized to provide similar services through a contract with the IDPH for local public health services. The agency must provide a current IDPH local public health services contract number.
- ◆ Home health agencies that are certified to participate in the Medicare program.
- ◆ Chore providers subcontracting with the Department on Aging.
- ◆ Community action agencies as designated in Iowa Code section 216A.93.
- ◆ Providers certified under an HCBS waiver for supported community living.
- ◆ Assisted living programs that are voluntarily accredited or certified by the Department of Inspections and Appeals under Chapters 69 and 70.
- ◆ Community businesses that are registered with the Iowa Secretary of State

The member or the legal representative of the member shall be responsible for selecting the person or agency that will provide the components of the attendant care services to be provided.

The Department of Human Services as the single state Medicaid agency has the same oversight responsibility for consumer-directed attendant care providers as it does for providers of any other home- and community-based waiver services.

Providers must demonstrate proficiency in delivery of the services included in a member's service plan. Proficiency must be demonstrated through documentation of prior training and experience or a certificate of formal training.

After the interdisciplinary team and member determine the adequacy of the training and experience, the member and provider shall complete form [470-3372, HCBS Consumer-Directed Attendant Care Agreement](#).

The case manager must review and approve form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, before the provision of services. Form 470-3372 becomes an attachment to and part of the service plan. Providers must document the delivery of services on form [470-4389](#).



Members will give direction and training for activities to maintain independence, which are not medical in nature. Licensed nurses and therapists will provide on-the-job training and supervision for skilled activities described on form 470-3372. All training and experience must be sufficient to protect the health, welfare, and safety of the member.

It is recommended that the provider receive certification of training for the following:

- ◆ Transferring
- ◆ Catheter assistance
- ◆ Medication aide

The role of the case manager is to assure that CDAC:

- ◆ Services are needed.
- ◆ Times and frequency are related to assessed needs.
- ◆ Agreement 470-3372 includes only payable CDAC services.
- ◆ Services are delivered as outlined in the agreement.

This would be especially needed in cases where the CDAC provider is the parent or guardian of an adult child.

## 9. Counseling Providers

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS/HIV	441 IAC 77.34(1)
Health and disability	441 IAC 77.30(6)

Counseling providers shall be:

- ◆ Agencies certified under the community mental health center standards established by the Mental Health and Developmental Disabilities Commission set forth in Department of Human Services rules 441 IAC 24, Divisions I and III.
- ◆ Agencies that are either:
  - Licensed as meeting the hospice requirements set forth in Department of Inspections and Appeals rule 481 IAC 53, or
  - Certified to meet the standards under the Medicare program for hospice programs.



- ◆ Agencies accredited under the mental health service provider standards established by the Mental Health and Developmental Disabilities Commission set forth in 441 IAC 24, Divisions I and IV.

## 10. Day Habilitation

### Legal Reference:

Waiver Type	Corresponding Iowa Administrative Code
Intellectual Disability	441 IAC 78.41(14)

The following providers may provide day habilitation:

- (1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).
- (2) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency’s last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under subparagraph 77.25(7) “a” (1), 77.25(7) “a” (4), or 77.25(7) “a” (7).
- (3) An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.
- (4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.
- (5) An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.
- (6) An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.
- (7) An agency that is accredited by the International Center for Clubhouse Development.
- (8) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.



Direct support staff providing day habilitation services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- (1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent degree. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.
- (2) A person providing direct support shall not be an immediate family member of the member.
- (3) A person providing direct support shall, within six months of hire or within six months of February 1, 2021, complete at least 9.5 hours of training in supporting members in the activities listed in 701—paragraph 78.27(8) “a,” as offered through DirectCourse or Relias or other nationally recognized training curriculum.
- (4) A person providing direct support shall annually complete 4 hours of continuing education in supporting members in the activities listed in 701—paragraph 78.27(8) “a,” as offered through DirectCourse or Relias or other nationally recognized training curriculum

## 11. Family Counseling and Training Providers

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 77.39(21)

Family counseling and training providers shall be one of the following:

- ◆ Providers that are certified under the community mental health center standards established by the Mental Health and Developmental Disabilities Commission set forth in 441 IAC 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441 IAC 83.81(249A).
- ◆ Providers licensed as meeting the hospice standards and requirements set forth in Department of Inspections and Appeals rules in 481 IAC 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441 IAC 83.81(249A).



- ◆ Providers accredited under the mental health service provider standards established by the Mental Health and Developmental Disabilities Commission set forth in 441 IAC 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441 IAC 83.81(249A).
- ◆ Individuals who meet the definition of qualified brain injury professional as set forth in rule 441 IAC 83.81(249A).
- ◆ Agencies certified as brain injury waiver providers pursuant to 441 IAC 77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441 IAC 83.81(249A).

**12. Home and Vehicle Modification Providers**

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Brain injury	441 IAC 77.39(16)
Elderly	441 IAC 77.33(9)
Health and disability	441 IAC 77.30(9)
Intellectual disability	441 IAC 77.37(17)
Physical disability	441 IAC 77.41(3)

The following providers may provide home and vehicle modifications:

- ◆ Department on Aging as designated in 321 IAC 4.4(231).
- ◆ Community action agencies as designated in Iowa Code section 216A.93.
- ◆ Providers eligible to participate as:
  - Home and vehicle modification providers under the elderly waiver,
  - Enrolled as home and vehicle modification providers under the physical disability waiver, or
  - Certified as home and vehicle modification providers under the intellectual disability or brain injury waiver.
- ◆ Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers’ compensation coverage, as required by law.



### 13. Home-Delivered Meals Providers

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 77.34(6)
Elderly	441 IAC 77.33(8)
Health and disability	441 IAC 77.30(11)

The following providers qualify to provide home-delivered meals:

- ◆ Area agencies on aging as designated in 17 IAC 4.4(231). Home-delivered meals providers subcontracting with area agencies on aging.
- ◆ Community action agencies as designated in Iowa Code section 216A.93.
- ◆ Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- ◆ Restaurants licensed and inspected under Iowa Code chapter 137F.
- ◆ Hospitals enrolled as Medicaid providers.
- ◆ Home health aide providers meeting the standards set forth in 441 IAC 77.33(3).
- ◆ Medical equipment and supply dealers certified to participate in the Medicaid program.
- ◆ Home care providers meeting the standards set forth in 441 IAC 77.33(4).

### 14. Home Health Aide Providers

**Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 77.34(2)
Elderly	441 IAC 77.33(3)
Health and disability	441 IAC 77.30(2)
Intellectual disability	441 IAC 77.37(20)

Home health aide providers shall be home health agencies that are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the Department.

## 15. Homemaker Providers

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS/HIV	441 IAC 77.34(3)
Elderly	441 IAC 77.33(4)
Health and disability	441 IAC 77.30(1)

Homemaker providers are agencies that meet one of the following two criteria:

- ◆ Authorized to provide similar services through a contract with the IDPH for local public health services. The agency must provide a current IDPH local public health services contract number.
- ◆ Agencies that are certified to participate in the Medicare program.

## 16. Interim Medical Monitoring and Treatment (IMMT) Providers

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS/HIV	441 IAC 77.39(25)
Health and disability	441 IAC 77.30(8)
Intellectual disability	441 IAC 77.37(22)

The following providers may provide interim medical monitoring and treatment services:

- ◆ Childcare facilities, which are defined as childcare centers licensed pursuant to 441 IAC Chapter 109, preschools, or child development homes registered pursuant to 441 IAC Chapter 110.
- ◆ Home health agencies certified to participate in the Medicare program.
- ◆ Supported community living providers certified according to 441 IAC 77.37(14) or 441 IAC 77.39(13).

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

- ◆ Be at least 18 years of age, and
- ◆ Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under, and
- ◆ Not be a usual caregiver of the member, and



- ◆ Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member’s plan of care. The training or experience required must be determined by the member’s usual caregivers and a licensed medical professional on the member’s interdisciplinary team and must be documented in the member’s service plan.

## 17. Nursing Care Providers

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 77.34(4)
Elderly	441 IAC 77.33(5)
Health and disability	441 IAC 77.30(4)
Intellectual disability	441 IAC 77.37(19)

Nursing care providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

## 18. Nutritional Counseling Providers

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Elderly	441 IAC 77.33(12)
Health and disability	441 IAC 77.30(12)

The following providers may provide nutritional counseling by a licensed dietitian under 645 IAC Chapter 81:

- ◆ Hospitals enrolled as Medicaid providers
- ◆ Community action agencies as designated in Iowa Code section 216A.93.ed in Iowa Code section 216A.93
- ◆ Nursing facilities licensed pursuant to Iowa Code chapter 135C
- ◆ Home health agencies certified by Medicare
- ◆ Independently licensed dietitians approved by the Department on Aging



## 19. Personal Emergency Response Services and Portable Locator Providers

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 77.39(17)
Elderly	441 IAC 77.33(2)
Health and disability	441 IAC 77.30(10)
Intellectual disability	441 IAC 77.37(18)
Physical disability	441 IAC 77.41(4)

Personal emergency response system and portable locator providers shall be agencies which meet the conditions of participation set forth in 441 IAC 77.33(2) to maintain certification.

## 20. Prevocational Service Providers

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 77.39(26)
Intellectual disability	441 IAC 77.37(26)

Providers of prevocational and career exploration services must be accredited by one of the following:

- ◆ The Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.
- ◆ The Council on Quality and Leadership accreditation in supports for people with disabilities.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- ◆ Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- ◆ Member vacation, sick leave, and holiday compensation.
- ◆ Procedures for payment schedules and pay scale.
- ◆ Procedures for provision of workers' compensation insurance.
- ◆ Procedures for the determination and review of commensurate wages.



Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

- ◆ A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.
- ◆ A person providing direct support shall not be an immediate family member of the member.
- ◆ A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.
- ◆ Prevocational direct support staff shall complete four hours of continuing education in employment services annually.

## **21. Residential-Based Supported Community Living Service Providers**

### **Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Intellectual disability	441 IAC 77.37(23)

The Department shall contract only with public or private agencies to provide RBSCL.

Subject to the requirements of this rule, the following agencies may provide RBSCL:

- ◆ Agencies licensed as group living foster care facilities under 441 IAC Chapter 114.
- ◆ Agencies licensed as residential facilities for intellectually disabled children under 441 IAC Chapter 116.



- ◆ All agencies providing RBSCL that meet the following conditions:
  - The agency shall provide orientation training on the agency’s purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children’s intellectual disability and developmental disabilities services and children’s mental health issues.
  - Identification and reporting of child abuse shall be covered in training at least every five years, in accordance with Iowa Code section 232.69.
- ◆ The agency must use methods of self-evaluation by which:
  - Past performance is reviewed,
  - Current functioning is evaluated, and
  - Plans are made for the future based on the review and evaluation.
- ◆ The agency must have a governing body that receives and uses input from a wide range of local community interests and member representatives and provides oversight that ensures the provision of high-quality supports and services to children.
- ◆ Children, their parents, and their legal representatives must have the right to appeal the service provider’s application of policies or procedures or any staff person’s action that affects the member. The service provider shall distribute the policies for member appeals and procedures to children, their parents, and their legal representatives.

As a condition of participation, all providers of RBSCL must have the following on file:

- ◆ Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations
- ◆ Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis
- ◆ The provider’s written agreement to work cooperatively with the Department

As a condition of participation, all providers of RBSCL must develop, review, and revise service plans for each child, as follows:

- ◆ The provider's service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.
- ◆ Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

The provider's service plan shall identify the following:

- ◆ Strengths and needs of the child.
- ◆ Goals to be achieved to meet the needs of the child.
- ◆ Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.
- ◆ Specific service activities to be provided to achieve the objectives.
- ◆ The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.
- ◆ Date of service initiation and date of individual service plan development.
- ◆ Service goals describing how the child will be reunited with the child's family and community.

Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on form [470-4694, Case Management Comprehensive Assessment](#), or as indicated by the Supports Intensity Scale Core Standardized Assessment.

The case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the case manager at six-month intervals and when changes to the service plan are needed.



The person-centered service plan shall be revised when any of the following occur:

- ◆ Service goals or objectives have been achieved.
- ◆ Progress toward goals and objectives is not being made.
- ◆ Changes have occurred in the identified service needs of the child, as listed on form 470-4694, *Case Management Comprehensive Assessment*, or as indicated by the Supports Intensity Scale Core Standardized Assessment.
- ◆ The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

The RBSCL service provider shall also furnish residential-based living units for all recipients of the RBSCL. Living units provided may be of no more than four beds.

## 22. Respite Care Providers

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 77.34(5)
Brain injury	441 IAC 77.39(14)
Children’s mental health	441 IAC 77.46(5)
Elderly	441 IAC 77.33(6)
Health and disability	441 IAC 77.30(5)
Intellectual disability	441 IAC 77.37(15)

The following agencies may provide respite services:

- ◆ Home health agencies that are certified to participate in the Medicare program
- ◆ Respite providers certified under the HCBS ID or BI waiver



- ◆ Nursing facilities, intermediate care facilities for the intellectually disabled, and hospitals enrolled as providers in the Iowa Medicaid program
- ◆ Group living foster care facilities for children licensed by the Department according to:
  - 441 IAC Chapter 112, and
  - 441 IAC Chapter 114, and
  - 441 IAC Chapter 115, and
  - 441 IAC Chapter 116
- ◆ Camps certified by the American Camping Association
- ◆ Home care agencies that meet the conditions of participation set forth in 441 IAC 77.30(1)
- ◆ Adult day care providers that meet the conditions of participation set forth in 441 IAC 77.30(3)
- ◆ Residential care facilities for persons with an intellectual disability licensed by the Department of Inspections and Appeals
- ◆ Assisted living programs certified by the Department of Inspections and Appeals

Respite 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, address, and the telephone number of each parent, guardian or primary caregiver
  - An emergency medical care release
  - Emergency contact telephone numbers such as the number of the member's physician and the parents, 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. Medications shall be stored so they are inaccessible to members and the public. Nonprescription medications shall be labeled with the 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.

Policies shall be developed for:

- ◆ Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent’s, guardian’s or primary caregiver’s signature is required to verify receipt of notification requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred before the respite provision.
- ◆ Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
- ◆ Ensuring the safety and privacy of the member. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

A facility providing respite under this subrule shall not exceed the facility’s licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the member’s home, or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

### **23. Senior Companions Providers**

#### **Legal reference:**

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Elderly	441 IAC 77.33(14)

Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.



## 24. Specialized Medical Equipment Providers

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 77.39(19)
Physical disability	441 IAC 77.41(5)

The following providers may provide specialized medical equipment:

- ◆ Medical equipment and supply dealers participating as providers in the Medicaid program
- ◆ Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined 441 IAC 78.43(8)

## 25. Supported Community Living Providers

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 77.39(13)
Intellectual disability	441 IAC 77.37(14)

The Department will contract only with public or private agencies to provide the supported community living service. The Department does not recognize individuals as service providers under the supported community living program.

Providers of services meeting the definition of foster care shall also be licensed according to:

- ◆ 441 IAC Chapter 108, and
- ◆ 441 IAC Chapter 112, and
- ◆ 441 IAC Chapter 114, and
- ◆ 441 IAC Chapter 115, and
- ◆ 441 IAC Chapter 116

Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to:

- ◆ 441 IAC Chapter 112, and
- ◆ 441 IAC Chapter 113



All supported community living providers shall meet the following requirements:

- ◆ The Department shall approve living units designed to serve four members except as necessary to prevent an overconcentration of supported community living units in a geographic area.
- ◆ The Department shall approve a living unit designed to serve five persons subject to both of the following conditions:
  - Approval will not result in an overconcentration of supported community living units in a geographic area.
  - The MHDS region in which the living unit is located provides to the Iowa Medicaid verification in writing that the approval is needed to address one or more of the following issues:
    - ◇ The quantity of services currently available in the county is insufficient to meet the need, or
    - ◇ The quantity of affordable rental housing in the county is insufficient, or
    - ◇ Approval will result in a reduction in the size or quantity of larger congregate settings.

The IME shall approve the five-person home application based on the letter of support from the MHDS region and the requirement to maintain the geographical distribution of supported community living programs to avoid an overconcentration of programs in an area.

## 26. Supported Employment Providers

### Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 77.39(15)
Intellectual disability	441 IAC 77.37(16)

The following agencies may provide supported employment services:

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



- ◆ An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.
- ◆ An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.
- ◆ An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.
- ◆ An agency that is accredited by the International Center for Clubhouse Development.

Providers responsible for the payroll of members shall have policies that include, but are not limited to:

- ◆ Member vacation, sick leave, and holiday compensation.
- ◆ Procedures for payment schedules and pay scale.
- ◆ Procedures for provision of workers' compensation insurance.
- ◆ Procedures for the determination and review of commensurate wages.
- ◆ Department of Labor requirements.

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:

- ◆ 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 nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.
- ◆ 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 or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.



- ◆ 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 or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
- ◆ Supported employment direct support staff shall complete four hours of continuing education in employment services annually.

The Department will contract only with public or private agencies to provide supported employment services. The Department does not recognize individuals as service providers under the supported employment program.

## 27. Transportation Providers

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
Brain injury	441 IAC 77.39(18)
Elderly	441 IAC 77.33(11)
Intellectual disability	441 IAC 77.37(24)
Physical disability	441 IAC 77.41(6)

The following providers may provide transportation:

- ◆ Accredited providers of home- and community-based services
- ◆ Regional transit agencies as recognized by the Iowa Department of Transportation
- ◆ Transportation providers that contract with county governments
- ◆ Community action agencies as designated in Iowa Code section 216A.93
- ◆ Nursing facilities licensed under Iowa Code chapter 135C
- ◆ Area agencies on aging as designated in rule 17 IAC 4.4(239), subcontractors of area agencies on aging
- ◆ Providers with purchase of service contracts to provide transportation pursuant to 441 Chapter 150
- ◆ Transportation providers contracting with the nonemergency medical transportation contractor

**a. Maintenance of Records**

**Legal reference:** 441 IAC 79.3(1), 441 IAC 79.3(2)

A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the Department or to its authorized representative timely upon request shall result in claim denial or recoupment.

**b. Provider Requirements for Service Documentation**

**Legal reference:** 441 IAC 79.3(2) "c" (3)

Providers shall maintain service and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

**c. Service Documentation**

The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

- ◆ The specific procedures or treatments performed.
- ◆ The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
- ◆ The complete time of the service, including the beginning and ending time (including AM and PM designation) if the service is billed on a time-related basis. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
- ◆ The location where the service was provided if otherwise required on the billing form, or in:
  - 441 IAC 77.30(5) "c" or "d,"
  - 441 IAC 77.33(6) "d,"
  - 441 IAC 77.34(5) "d,"
  - 441 IAC 77.37(15) "d,"
  - 441 IAC 77.39(13) "e,"
  - 441 IAC 77.39(14) "d,"
  - 441 IAC 77.46(5) "i" or
  - 441 IAC 78.9(10) "a" (1).

- ◆ The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
- ◆ Any supplies dispensed as part of the service.
- ◆ The first and last name and professional credentials, if any, of the person providing the service. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

For 24-hour care, documentation for every shift of the services provided, including the member's response to the services provided and the person who provided the services.

**d. Outcome of Service**

**Legal reference:** 441 IAC 79.3(2) "c" (4)

The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of plan of care, or diagnosis.

**e. Basis of Service**

**Legal reference:** 441 IAC 79.3(2) "d"

The medical record must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it).

Basis for service requirements for specific services other than case management include:

- ◆ Notice of decision for service authorization
- ◆ Provider's service plan and the *Comprehensive Person-Centered Service Plan* (initial and subsequent)
- ◆ Service documentation, logs, notes, or narratives
- ◆ Mileage and transportation logs
- ◆ Log of meal delivery
- ◆ Invoices or receipts

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- ◆ [Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement](#)
- ◆ [Form 470-4389, Consumer-Directed Attendant Care \(CDAC\) Daily Service Record](#)

Case management services, including HCBS case management services:

- ◆ Notice of decision for service authorization.
- ◆ Service notes or narratives.
- ◆ Social history.
- ◆ Comprehensive service plan.
- ◆ Reassessment of member needs.
- ◆ Incident reports in accordance with 441 IAC 24.4(5).

## E. Audits or Review of Provider Records

Any Medicaid provider may be audited or reviewed at any time at the discretion of the Department.

Authorized representatives of the Department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

- ◆ The Department has correctly paid claims for goods or services.
- ◆ The provider has furnished the services to Medicaid members.
- ◆ The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- ◆ The goods or services provided were in accordance with Iowa Medicaid policy.

Requests for provider records by the Iowa Medicaid Program Integrity Unit shall include form 470-4479, *Program Integrity Unit Documentation Checklist*, listing the specific records that must be provided for the audit or review pursuant to paragraph 441 IAC 79.3(2) "d" to document the basis for services or activities provided.

### Audit or Review Procedures

The Department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the Department. Unless the Department specifies otherwise, the provider may select the method of delivering any requested records to the Department.

Upon a written request for records, the provider must submit all responsive records to the Department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided below:

- ◆ The Department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:
  - Establish good cause for the delay in submitting the records, and
  - Be received by the Department before the date the records are due to be submitted.

**NOTE:** "Good cause" has the same meaning as in Iowa Rule of Civil Procedure 1.977.

- ◆ The Department may grant a request for an extension of the time limit for submitting records at its discretion. The Department shall issue a written notice of its decision.
- ◆ The provider may appeal the Department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441 IAC Chapter 7.
- ◆ The Department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.
- ◆ For an announced on-site review or audit, the Department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.
- ◆ Notice is not required for unannounced on-site reviews and audits.
- ◆ In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.
- ◆ Audit or review procedures may include, but are not limited to, the following:
  - Comparing clinical and fiscal records with each claim.
  - Interviewing members who received goods or services and employees of providers.
  - Examining third-party payment records.
  - Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.
  - Examining all documents related to the services for which Medicaid was billed.



If the Department concludes from an audit or review that an overpayment has occurred, the Department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the Department and may present clarifying information and supplemental documentation.

A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441 IAC Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Evidence shall not be admissible in any subsequent contested case proceeding or other action relating to, or arising out of, the finding and order for repayment of any overpayment under 441 IAC 79.4(6). Examples of admissible evidence include, but are not limited to, records, clarifying information, or supplemental documentation that was not provided to the Department in a timely manner as stated in 441 IAC 79.4(3) or (5). The purpose of the appeal is to verify whether the Department correctly calculated any overpayment based on the information provided to the Department during its audit or review.



## F. Authorization for Provision of Services

### HCBS Waiver Eligibility Determination

To be determined eligible for HCBS waiver services, the applicant must have both functional Level of Care and financial eligibility approval.

The member or the parent or guardian must be given informed choice of the following:

- ◆ The type of waiver the member receives
- ◆ The provider for each service the member receives
- ◆ Where the member works
- ◆ Where the member resides
- ◆ Where and how the member spends the member's free time
- ◆ The member's daily routine
- ◆ To have an impact on the services the member receives

All services are provided to eligible members according to the member's individualized need as identified in the service plan and based on the type of waiver the member receives. Before service provision, the provider must obtain documentation of service authorization. The documentation of service authorization should include a copy of the Notice of Decision or Notice of Authorization that would include:

- ◆ The name of the provider,
- ◆ The provider number,
- ◆ The service and procedure code,
- ◆ The number of units to be provided,
- ◆ The approved rate for each service, and
- ◆ The date span of the specific service.

The following sections list the general exclusion and limitations of waiver services.

#### **EXCLUSIONS:**

##### ◆ **Services Otherwise Available**

Members may use services available under the regular State Medicaid Plan in addition to using the waiver services. When a service is available through the state plan, the member must first access the state plan before accessing the waiver. When the same or similar service is available from an alternate source free of charge, the member must use that service before using the waiver services.



Home health aide and nursing care services are available to people aged 20 or under through the Care for Kids (EPSDT) program when the need for home health aide service exceeds the service available through regular Medicaid.

Nursing and home health aide services for people aged 21 and over may be reimbursed through the waiver only after the regular State Medicaid Plan or alternate source reimbursement limits are met.

Members must obtain durable medical equipment available under the state Medicaid program, if applicable, before accessing the waiver's home and vehicle modification, assistive device or specialized medical equipment service.

◆ **Duplicate Services**

A member may be enrolled in only one waiver program at a time. For example, a person enrolled in the HCBS health and disability waiver may not be enrolled in the HCBS intellectual disability waiver at the same time.

Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility).

Services may not be simultaneously reimbursed for the same time period. For example, only one provider may be reimbursed for one service during a specified hour, even if two providers arrive at the member's home at the same time to provide different services.

Waiver members may also access state plan HCBS habilitation services. A waiver member who is enrolled in the state plan HCBS habilitation program must access the state plan services available through habilitation before accessing the waiver services.

Participation in both HCBS waiver and state plan HCBS habilitation programs is not considered duplicative when the member accesses different services under each program. For example, a member may access transportation through the waiver and supported employment through state plan habilitation.

## G. Quality Management Activities

**Legal reference:** 441 IAC 77.37(13), 441 IAC 77.39(13)

HCBS quality reviewers may evaluate the following provider documentation in conjunction with quality reviews:

- ◆ Personnel records,
- ◆ Member service records,
- ◆ Agency policies and procedures,
- ◆ Evidence to support implementation of agency policy and quality improvement activities, and
- ◆ Other information as requested.

HCBS quality reviewers may interview the following:

- ◆ Agency staff.
- ◆ Members accessing the services and their legal representatives.
- ◆ Case managers or integrated health home.
- ◆ Agency board members; and
- ◆ Others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

The HCBS program may issue commendations, recommendations, corrective actions or sanctions as a result of the review.

Corrective action shall be required when noncompliance with the agency policies, Iowa Code, Iowa Administrative Code, or Federal Code of Regulations are identified. A compliance review of any corrective action will occur within 60 business days of the HCBS program's approval of the plan.

The following activities apply to providers of the services under the HCBS program:

- ◆ **Self-assessment.** Providers are required to annually submit the *Provider Quality Management Self-Assessment* to the Department by December 1. The provider will verify the accuracy of the self-assessment through the submission of the Guarantee of Accuracy statement.
- ◆ **Focused review.** Providers will submit evidence of the implementation of provider policies upon request from the HCBS program. The HCBS program may issue commendations, recommendations, corrective actions or sanctions as a result of the review.



- ◆ **Targeted review.** Reviews shall occur at the discretion of the Department. The HCBS program may issue commendations, recommendations, corrective actions, or sanctions as a result of the review.
- ◆ **Periodic on-site review.** Reviews shall occur on a cyclical basis of at least once every five years. Periodic on-site reviews shall be conducted with providers that are currently providing services to members or have provided services in the previous 12 months of the on-site review notice.

## H. Incident Reporting

**Legal reference:** 441 IAC 77.37(8)

As a condition of participation in the medical assistance program, HCBS waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

HCBS waiver service providers, case managers, targeted case managers, and IHH care coordinators are required to submit an incident report to the Bureau of Medical and Long-Term services and Supports (MLTSS) when a major incident has been witnessed or discovered. If the case manager or IHH care coordinator is not certain a major incident has been reported by a member’s provider, please ensure the report is submitted either through communication with the service provider or by personally submitting the incident report via the [Iowa Medicaid Portal Access \(IMPA\)](#).

**EXCEPTION:** The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals or personal emergency response.

**“Major incident”** means an occurrence involving a member enrolled in HCBS waiver services 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.
- ◆ Results in emergency mental health treatment for the member.
- ◆ Results in the intervention of law enforcement.
- ◆ 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, and 5 above.
- ◆ Involves a member’s location being unknown by provider staff who are assigned protective oversight.

“**Member**” means a person who has been determined to be eligible for Medicaid under 441 IAC Chapter 83.

“**Minor incident**” means an occurrence involving a member enrolled in HCBS waiver services that is not a major incident and that:

- ◆ Results in the application of basic first aid,
- ◆ Results in bruising,
- ◆ Results in seizure activity,
- ◆ Results in injury to self, to others or to property, and
- ◆ Constitutes a prescription medication error.

### **1. Reporting Procedure for Minor Incidents**

Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained by the provider in a centralized file with a notation in the member’s file.

### **2. Reporting Procedure for Major (Critical) Incidents**

In order for the critical incident to trigger the necessary workflow and milestones in the IoWANS for case managers, form [470-4698, Iowa Medicaid Critical Incident Report](#) for FFS members must be submitted through the Iowa Medicaid Portal Access (IMPA) system.

When a major incident occurs, or a staff member becomes aware of a major incident:

- ◆ The staff member shall notify the following persons of the incident by the end of the next business day:
  - The staff member’s supervisor.
  - The member and the member’s legal guardian, as applicable; and
  - The member’s case manager or IHH.



- ◆ By the end of the next business day 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 IME by direct data entry into the Iowa Medicaid Portal Access (IMPA). The following information shall be reported:
  - The name of the member involved.
  - The date, time, and location where the incident occurred or was discovered.
  - A description of the incident.
  - 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 Medicaid eligible or non-Medicaid-eligible persons who were present must be maintained using initials or other means; and
  - The action that the provider staff took to manage the incident; and
  - The type of incident as defined in 441 IAC Chapter 77.

Submission of the initial report will generate a workflow in IoWANS for follow-up by the case manager, or integrated health home. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports within five business days. The completed report shall be maintained by the provider in a centralized file with a notation in the member's file.

The investigation findings and resolution of the incident shall be reported in the IMPA system within 30 calendar days of the initial report. Below are reminders when submitting the report.

- ◆ All Critical Incident Reports are uploaded in IMPA by selecting "File > Upload File > Critical Incident Report".
- ◆ Critical Incident Reports are not accepted if they are submitted by fax, email, or by uploading to the incorrect location in IMPA.
- ◆ Do not submit Critical Incident Reports to the Iowa Medicaid for members who are enrolled with a Managed Care Organization (MCO). Follow the MCO's incident reporting procedures.
- ◆ Do not submit more than one incident report for the same incident.

Additional information may be submitted after an incident has been entered into IMPA. To do this, locate the incident in IMPA and click on the pencil under the note column to add the updated information.



## I. Financial Participation

Persons must contribute their predetermined financial participation to the cost of HCBS waiver services or other Medicaid services, as applicable.

### 1. Client Participation and Financial Participation

#### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
All waiver types	441 IAC 75.16(249A)
AIDS/HIV	441 IAC 83.44(1)
Brain injury	441 IAC 83.84(1)
Children’s mental health	441 IAC 83.124(249A)
Elderly	441 IAC 83.24(1)
Health and disability	441 IAC 83.4(1)
Intellectual disability	441 IAC 83.63(1)
Physical disability	441 IAC 83.104(1)

Client participation is the amount the member is required to contribute towards the cost of waiver services.

The income maintenance worker will determine the client participation amount for each member.

The case manager must assign client participation to one or more of the wavier services listed in the IOWANS service plan. The notice of decision sent to the member and the provider must show the amount of client participation that the member must pay to the provider for services rendered.

If a member has client participation (veteran’s aid and attendance or a medical assistance income trust) which covers all or part of the cost of a service, the provider must bill the member for their portion of the client participation. After client participation has been met, then the provider bills Iowa Medicaid the difference in this amount by subtracting off the amount of client participation.

For members enrolled for fee-for-service, the case manager or makes an entry on the member’s *Notice of Decision: Services*, form 470-0602, in the section entitled “Fees” when the member has client participation. In addition, the case manager should show the amount or source of client participation in the case plan.



NOTE: Under the **CMH** waiver, client participation is identified as financial participation. A member must contribute to the cost of children’s mental health waiver services to the extent of the member’s total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

## 2. Limit on Payment

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
AIDS/HIV	441 IAC 83.44(2)
Brain injury	441 IAC 83.84(2)
Elderly	441 IAC 83.24(2)
Health and disability	441 IAC 83.4(2)
Intellectual disability	441 IAC 83.63(2)
Physical disability	441 IAC 83.104(2)

If for any month, the sum of the third-party payment and client participation equals or exceeds the waiver service plan established by the case manager, Medicaid will make no payments to waiver service providers. However, Medicaid will make payments to other medical vendors as applicable.

## 3. Third-Party Payments

### Legal reference:

<b>Waiver Type</b>	<b>Corresponding Iowa Administrative Code</b>
All waiver types	441 IAC 75.2(2)
AIDS/HIV	441 IAC 83.44(2)
Brain injury	441 IAC 83.84(2)
Elderly	441 IAC 83.24(2)
Health and disability	441 IAC 83.4(2)
Intellectual disability	441 IAC 83.63(2)
Physical disability	441 IAC 83.104(2)

Payment will be approved only for those services or for that part of a given service for which no medical resources exist. The provider must inform the Department by a notation on the claim form that other coverage exists but did not cover the service being billed, or that payment was denied.

If a member has insurance that covers all or part of a service, the insurance company must be billed before billing Medicaid for the service.

## J. Basis of Payment

**Legal reference:** 441 IAC 79.1(15)

The design of the cost principles, administrative rules, and support of reporting for HCBS waiver services reflects the Department's intent to establish rates for care based on "necessary and reasonable" costs of providing the services within the established standards.

Reimbursable costs must meet two tests:

- ◆ Necessary. Essential to the provision of home- and community-based waiver services and to the achievement of service requirements and outcomes.
- ◆ Reasonable. At levels considered appropriate for the provision of quality care in Iowa within the established standards.

The basis of payment for services rendered by providers of services participating with the HCBS waivers is either a system based on the provider's allowable costs of operation or a fee schedule (Medicare or Medicaid). Providers of service must accept reimbursement based upon the Department's methodology without making any additional charge to the member (except for designated copayments).

### 1. Types of Reimbursement

#### a. Fee Schedules

Fees for the various procedures involved are determined by the Department with advice and consultation from the appropriate professional group. The fees are intended to reflect the number of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others.

If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- ◆ The actual charge made by the provider of service, or
- ◆ The maximum allowance under the fee schedule for the item of service in question.

**b. Retrospectively Limited Prospective Rate (See 79.1(15))**

Providers are reimbursed based on a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each member or site) based on projected or historical costs of operation subject to the maximums listed in subrule 441 IAC 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1) "e" (3).

- ◆ The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.
- ◆ The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.
- ◆ The prospective rates paid to both new and established providers are subject to:
  - Maximums listed in subrule 441 IAC 79.1(2), and
  - Retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider. Retrospective adjustments shall not exceed reasonable and proper costs actually incurred by more than 4.5 percent.

HCBS providers must submit a cost report for waiver services using form 470-0664, *Financial and Statistical Report for Purchase of Service Contracts*. All financial and statistical reports must meet the specifications described in this section and in 441 IAC 79.1(15). The provider completes the form or is responsible for its content, regardless of if it is prepared by someone outside the agency.

**2. Maintenance and Retention of Financial and Statistical Record**

The financial information included in form 470-0664 must be taken from financial and statistical records and must be verifiable by qualified auditors. To provide the required cost data and not impair comparability, maintain financial and statistical records in a consistent manner from one period to another.



Sufficient financial and statistical records should be maintained to document the validity of reports submitted to the Department. This includes program and census data. Failure to maintain records to support cost reports may result in removal of costs or termination of the provider's HCBS certification.

These records include, but are not limited to:

- ◆ All bank statements and vendor invoices (paid and unpaid)
- ◆ Payroll information
- ◆ General ledger reconciliation to financial and statistical report
- ◆ Expense allocation schedules
- ◆ Time studies to support expense allocations
- ◆ Financial statements or audit reports (if any)
- ◆ Loan agreements and other contracts
- ◆ Capital asset schedules including information to calculate depreciation on a straight-line method
- ◆ Documentation of units of services provided to members
- ◆ Reviewable, legible census reports
- ◆ Board of director's minutes (if applicable)

All financial and statistical reports, and records to support them, should be maintained for a minimum of five years after final notification of rate and cost report reconciliation. Reports and records should be made available to authorized representatives and agents of the Department and of the United States Department of Health and Human Services, upon request.



### 3. Submission of the Financial and Statistical Reports

Iowa Medicaid providers that provide the following HCBS waiver services are required to submit reports in accordance with Iowa Administrative Code (IAC).

		ID Waiver	BI Waiver	HD Waiver	CMH Waiver
<b>Supported Community Living (SCL)</b>	Daily	X	X		
	15 min	X	X		
<b>Interim Medical Monitoring and Treatment (IMMT)</b>		X	X	X	
<b>Family &amp; Community Support Services</b>					X

For the HCBS Cost Report Form 470-5477 click [here](#).

For the HCBS Cost Report Form Instructions click [here](#)

*HCBS Supplemental Schedule D-4* projected worksheets from form 470-3449 must be signed and dated by an Officer or Administrator of the agency. *HCBS Supplemental Schedule D-4 (Individual Daily Rate Worksheets)* from form 470-3449 must also be signed by the member’s case manager.

Completed and signed projected rate worksheets should be emailed to [costaudit@dhs.state.ia.us](mailto:costaudit@dhs.state.ia.us), or sent to the following address:

Iowa Medicaid  
 Provider Cost Audit and Rate Setting  
 PO Box 36450  
 Des Moines, IA 50315

**a. Instructions for HCBS Supplemental Schedule D-4, Form 470-3449**

The purpose of *HCBS Supplemental Schedule D-4*, form 470-3449, *Daily Rate Worksheet*, is to calculate a unit daily rate cost per living site. Costs reported by site should be consistent with those reported on *Schedule D* from form 470-0664.

Projected prospective rates are based on projected reasonable and proper costs of operation for a 12-month period.

The *HCBS Supplemental Schedule D-4*, form 470-3449, consists of two parts:

- ◆ Site Daily Rate Worksheet
  - Sum total of the *Individual Daily Rate Worksheets* which calculates the average daily rate for the separate ID, RBSCL, or BI site
  - Separate *Site Daily Rate Worksheet* must be submitted for a BI site
  - Completed, signed, and submitted by the provider
- ◆ Individual Daily Rate Worksheet
  - Completed for each member living at the site
  - Completed and signed by the interdisciplinary team including the provider and the case manager
  - Submitted by the provider

Submit a *HCBS Supplemental Schedule D-4*, form 470-3449, for the site rates (*Site Daily Rate Worksheet*) along with separate schedules for each member (*Individual Daily Rate Worksheet*). The *Individual Daily Rate Worksheets* must be submitted for each member even if all members share the same rate at the site.

*Supplemental Schedule D-4* should be completed for the following reasons:

- ◆ To establish a daily rate for a new site.
- ◆ To change a daily rate due to significant changes in the cost per unit for a member due to:
  - Change in member service needs.
  - Change in members at the site.

A "significant" change occurs when a member's functioning level changes or a vacancy is unable to be filled within 30 days. Give a full explanation of the changes in the living site situation on the schedule. Also give reasons for a request to exceed the unique rate maximum.

A *Supplemental Schedule D-4* may be submitted no more than once every three months for the above reasons. The projected rate established will not be inflated by an inflation factor.

A provider can choose to either bill member rates or an average site rate for each member at the living site. Regardless of choice, both site and individual daily rate worksheets for each member living at the site must be submitted with each projected *Supplemental Schedule D-4*.

**b. Instructions for BI Waiver *Site Daily Rate Worksheet***

- ◆ **Effective Date.** Effective date requested for the rates.
- ◆ **Provider Name.** Agency name.
- ◆ **NPI.** 10-digit NPI number.
- ◆ **Site Rate/Individual Rate.** Check box to indicate if rates requested are site or individual rates.
- ◆ **New Site.** Check box if the *Supplemental Schedule D-4* is being submitted to establish a daily rate for a new site.
- ◆ **Existing Site Change.** Check box if the *Supplemental Schedule D-4* is being submitted to change an existing site rate.
- ◆ **Site Name.** If the *Supplemental Schedule D-4* is being submitted to change an existing site rate, include the site name of the site being changed.
- ◆ **Site Address and City.** Enter street address and city of site.
- ◆ **Explanation of Changes.** If the *Supplemental Schedule D-4* is being submitted to change an existing site rate, include an explanation of the significant changes in the living site situation.
- ◆ **List all Members living at the site.** Each member living at the site, regardless of funding, must be included in the table. The table will include member identification, member name, case manager name, and funding (e.g., Money Follows the Person, ID, BI, county, private pay, or habilitation).
- ◆ **Waiver Type.** Enter waiver type (e.g., ID, BI, RBSCCL) for the site rate being submitted. Ensure only expenses and units for the appropriate waiver type are entered.

Sum the amounts from the *Individual Daily Rate Worksheets*, by line item for each specific waiver type. Show the lower of actual indirect costs or the 20 percent limit and add it to total direct costs. Then divide total costs by the units of service provided to calculate a unit cost. Each separate *Site Daily Rate Worksheet* will only include expenses and units for that specific waiver type.

**c. Instructions for BI Waiver *Individual Daily Rate Worksheet***

- ◆ **Effective Date.** Effective date requested for the rates.
- ◆ **Provider Name.** Agency name.
- ◆ **NPI.** 10-digit NPI number.
- ◆ **Site Name.** If the *Supplemental Schedule D-4* is being submitted to change an existing site rate, including the site name of the site being changed.
- ◆ **Member Name.** Name of member.
- ◆ **Member ID.** Medicaid identification number of member.
- ◆ **Case Manager.** Name of case manager responsible for member service plan.
- ◆ **Indicate if member had a change in service plan.** A separate *Individual Daily Rate Worksheet* is completed for every member living at the site. "Y" is entered if a service plan change for this member has occurred to necessitate the rate change.
- ◆ **Explanation of Changes.** If the member had a change in service plan which has resulted in a change in rate, include an explanation of the service plan changes and how the changes affected the individual rate.
- ◆ **Show direct costs by line item.** Use actual costs for members and living sites not undergoing any significant change. Use projected costs if there are no representative historical costs available or for a member or living site that undergoes a significant change during the reporting period.
- ◆ **Project the costs on an annual period:** Line 3290 – Other Related Transportation, Line 3520 – Other Assistance, and Line 4320 – Other Equipment Repair and Purchase, are for member-specific support expenses and shall not exceed \$1,570 reimbursement per member per year. The provider must maintain records to support the expenditures.



- ◆ **Show the lower of actual indirect costs or the 20 percent limit.** Add it to total direct costs, then divide total costs by the units of service provided to calculate a unit cost.
- ◆ **Staffing Schedule:** Provide an individual staffing schedule for each member, which supports the salary expense and hours included on the *Individual Daily Rate Worksheet*. The schedule should include times of day, staff to member ratios, any other services provided to the member, and total hours. Provide any additional explanations for needed changes in services or expenses submitted on the worksheets.

### K. HCBS Waiver Billing Codes

Iowa Medicaid has identified specific Healthcare Common Procedure Codes (HCPC) procedure codes and level II modifiers for the purposes of authorization and reimbursement of HCBS Waiver services. Use of the correct procedure code and modifier supports accurate reporting of service utilization and expenditures.

HCBS Waiver services must be authorized, and claims must be submitted for payment using the specific HCPCs code and modifier combinations designated for the specific HCBS waiver service.

Case Managers and IHH Care Coordinators must use the following procedure codes and modifiers to identify waiver services in the waiver member’s comprehensive person-centered service plan. Providers of HCBS waiver services must use the following procedure codes and modifiers to submit claims for payment.

#### HCBS Waiver Billing Code Chart

Service	AIDS/ HIV	BI	CMH	Elderly	HD	ID	PD	Modifier
Adult day care; half day	S5101	S5101		S5101	S5101	See table below		None
Adult day care; full day	S5102	S5102		S5102	S5102	See table below		None
Adult day care; extended day	S5105	S5105		S5105	S5105	See table below		None



Service	AIDS/HIV	BI	CMH	Elderly	HD	ID	PD	Modifier
Adult day care; hourly	S5100	S5100		S5100	S5100	See table below		None
Assisted living services				T2031				None
Assistive devices per item				S5199				None
Behavioral programming (i.e., health and behavioral intervention); 15 minute unit		96152						None
Behavioral programming (i.e., mental health plan development); 15 minute unit		H0032						None
Behavioral programming (mental health assessment); 15 minute unit		H0031						None
Case management (targeted or waiver); 15 minute unit		T1016	T1017	T1016		T1017		None
CDAC (agency); 15 minute unit	S5125	S5125		S5125	S5125	S5125	S5125	No modifier = unskilled Modifier U3 = skilled
CDAC (individual); 15 minute unit	T1019	T1019		T1019	T1019	T1019	T1019	No modifier = unskilled Modifier U3 = skilled
Chore; 15 minute unit				S5120				None
Counseling (individual); 15 minute unit	H0004				H0004			None
Counseling (group); 15 minute unit	96153				96153			None
Day habilitation; per day						See table below		None
Day habilitation; 15 minute unit						See table below		None



Service	AIDS/ HIV	BI	CMH	Elderly	HD	ID	PD	Modifier
Environmental modifications and adaptive devices (home modification); per item			S5165					None
Environmental modifications and adaptive devices (personal care items); per item			S5199					None
Environmental modifications and adaptive devices (specialized supply); per item			T2028					None
Family and community support; 15 minute unit			H2021					None
Family counseling and training; 15 minute unit		H2021						None
Financial management services; per month	T2025	T2025		T2025	T2025	T2025	T2025	None
Home-delivered morning meals; per meal	S5170			S5170	S5170			UF required
Home-delivered liquid supplemental meal; two cans per meal	S5170			S5170	S5170			UJ required
Home-delivered noon meals; per meal	S5170			S5170	S5170			UG required
Home-delivered evening meals; per meal	S5170			S5170	S5170			UH required
Home health aide; 15 minute unit	T1021			T1021	T1021	S9122		None
Homemaker; 15 minute unit	S5130			S5130	S5130			None
Home and vehicle modification (home modifications only); per service		S5165		S5165	S5165	S5165	S5165	None



Service	AIDS/ HIV	BI	CMH	Elderly	HD	ID	PD	Modifier
Home and vehicle modification (vehicle modifications only); per service		T2039		T2039	T2039	T2039	T2039	None
IMMT (HH agency home health aide); 15 minute unit		T1004			T1004	T1004		None
IMMT (HH agency RN); 15 minute unit		T1002			T1002	T1002		None
IMMT (HH agency LPN); 15 minute unit		T1003			T1003	T1003		None
IMMT (SCL and child care center); 15 minute unit		T1004			T1004	T1004		Requires use of U3
IMMT (group); 15 minute unit		T1004						
In-home family therapy; 15 minute unit			H0046					None
Mental health outreach; 15 minute unit				H0036				None
Nursing (RN); per visit	T1030			T1030	T1030			
Nursing (LPN); per visit	T1031			T1031	T1031			
Nursing (RN); per hour						S9123		
Nursing (LPN); per hour						S9124		
Nutritional counseling (initial); 15 minute unit				97802	97802			None
Nutritional counseling (subsequent); 15 minute unit				97803	97803			None
Personal emergency response (initial fee for install)		S5160		S5160	S5160	S5160	S5160	None
Personal emergency response (monthly)		S5161		S5161	S5161	S5161	S5161	None



Service	AIDS/HIV	BI	CMH	Elderly	HD	ID	PD	Modifier
Prevocational services; per hour		T2015				T2015		None
Prevocational – career exploration		T2015 U3				T2015 U3		U3
Respite (Home Care Agency, individual basic) 15 minute unit	S5150	S5150	S5150	S5150	S5150	S5150		UC
Respite (HH agency, specialized); 15 minute unit	S5150	S5150	S5150	S5150	S5150	S5150		Specialized requires use of U3; individual must not have a modifier
Respite (HH agency, basic individual); 15 minute unit	S5150	S5150	S5150	S5150	S5150	S5150		Specialized requires use of U3; individual must not have a modifier
Respite (HH agency group); 15 minute unit	T1005	T1005	T1005	T1005	T1005	T1005		None
Respite (home/non-facility, specialized); 15 minute unit	S5150	S5150	S5150	S5150	S5150	S5150		Specialized requires use of U3; individual must not have a modifier
Respite (home/non-facility basic individual); 15 minute unit	S5150	S5150	S5150	S5150	S5150	S5150		Specialized requires use of U3; individual must not have a modifier
Respite (home non-facility, group); 15 minute unit	T1005	T1005	S5150	T1005	T1005	T1005		None
Respite (hospital or NF) <ul style="list-style-type: none"> <li>• RCF</li> <li>• Adult day care</li> <li>• Child care facility</li> <li>• ICF/ID</li> <li>• Foster group care</li> </ul> 15 minute unit	T1005	T1005	T1005	T1005	T1005	T1005		U3 required



Service	AIDS/ HIV	BI	CMH	Elderly	HD	ID	PD	Modifier
Respite (resident camp); 15 minute unit	T2036	T2036	T2036	T2036	T2036	T2036		None
Respite (group day camp)	T2037	T2037	T2037	T2037	T2037	T2037		
Senior companion; 15 minute unit				S5135				None
Specialized medical equipment; per item		T2029					T2029	None
Supported community living; daily		H2016				See table Below		BI waiver must not have a modifier
Supported community living; 15 minute unit		H2015				H2015		ID waiver requires use of HI; BI waiver must not have a modifier
Supported community living (residential-based); daily						See table Below		Requires use of U3 for RBCSL
Supported employment		See table below.				See table below.		
Transportation; per mile; individual		S0215		S0215		S0215	S0215	None
Transportation; per mile; group		S0215		S0215		S0215	S0215	U3
Transportation; 1-way trip; individual		T2003		T2003		T2003	T2003	None
Transportation; 1-way trip; group		T2003		T2003		T2003	T2003	U3
Transportation; non-emergent wheelchair van; individual; trip		A0130		A0130		A0130	A0130	None
Transportation; non-emergent wheelchair van; group; trip		A0130		A0130		A0130	A0130	U3
Transportation; non-emergent escort; trip		T2001		T2001		T2001	T2001	None
Workman's compensation	T2025	T2025		T2025	T2025	T2025	T2025	UC required



Please see the following Fee Schedules for additional information:

- ◆ [HCBS Intellectual Disability Waiver Tiered Rates](#)
- ◆ [HCBS Prevocational and Supported Employment Services](#)
- ◆ [MHDS Regional Average NEMT Rates for HCBS Waiver Transportation](#)

ID Waiver Tiered Rate Procedure Codes		
SERVICE	TIER	CODE
Supported Community Living (SCL)- without day service*	1	H2016 U1
	2	H2016 U2
	3	H2016 U3
	4	H2016 U4
	5	H2016 U5
	6	H2016 U6
SCL Provided in a Residential Care Facility (RCF) licensed for 6 or more beds - without day services*		H2016 HI
Supported Community Living - with day service**	1	S5136 U1
	2	S5136 U2
	3	S5136 U3
	4	S5136 U4
	5	S5136 U5
	6	S5136 U6
SCL Provided in a Residential Care Facility (RCF) licensed for 6 or more beds - with day services**		S5136 HI
Residential Based Supported Community Living (RBSCCL)		S5136 UA
Day Habilitation	1	T2020 U1
	2	T2020 U2
	3	T2020 U3
	4	T2020 U4
	5	T2020 U5
	6	T2020 U6
Adult Day Service	1	S5102 U1
	2	S5102 U2
	3	S5102 U3
	4	S5102 U4
	5	S5102 U5
	6	S5102 U6



Supported Employment	Procedure Code and Modifier	Basis	Unit of Service
Individual Supported Employment	T2018 UC	Fee schedule	Hourly
Long term Job Coaching:			
Tier 1 = 1 Contact per month	H2025 U4	Fee schedule	Month
Tier 2 = 2-8 Hours per month	H2025 U3	Fee schedule	Month
Tier 3 = 9-16 Hours per month	H2025 U5	Fee schedule	Month
Tier 4 = 17-25 Hours per month	H2025 U7	Fee schedule	Month
Tier 5 = 26+ Hours per month	H2025 UC	Fee schedule	Hour
Supported Employment – Small Group			
Tier 1 = Groups of 2 to 4	H2023 U3	Fee schedule	Per person, 15-minute unit
Tier 2 = Groups of 5 or 6	H2023 U5	Fee schedule	Per person, 15-minute unit
Tier 3 = Groups of 7 or 8	H2023 U7	Fee schedule	Per person, 15-minute unit

**L. Billing Policies and Claim Form Instructions**

Services must be billed in whole units.

For all services with a 15-minute unit of service, the following rounding process will apply:

- (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
- (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
- (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
- (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day

Claims for waiver providers are billed on form [470-2486, Claim for Targeted Medical Care](#). Click [here](#) to view the claim form instructions.

This form may be obtained from Iowa Medicaid Provider Services at (800) 338-7909 or, in the Des Moines area at (515) 256-4609.



Claims submitted electronically shall be filed on the Accredited Standards (ASC) X12N 837 transaction, Health Care Claim.

Refer to Chapter IV. *Billing Iowa Medicaid* for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:  
<http://dhs.iowa.gov/sites/default/files/All-IV.pdf>

Iowa Medicaid providers are required to process claims electronically through the Iowa Medicaid and MCOs.

The Iowa Medicaid offers the following options for providers to consider for electronic billing:

- ◆ ABILITY PC-ACE Pro: This software is available to all providers through Iowa Medicaid for billing FFS claims. Contact Iowa Medicaid at the number below for additional information. There is no cost for FFS member claims billed through ABILITY PC-ACE Pro.
- ◆ MCO portals: Each MCO has an online portal for claim submission management. Contact the MCOs at the numbers listed below for additional information.
  - [Iowa Total Care](#)
  - [Amerigroup Iowa, Inc.](#)
- ◆ Electronic Data Interchange (EDI) Clearinghouse Options: EDI Clearing House options are available that can be used to bill both FFS and MCO claims.

For electronic billing information and tips click [here](#).

The Billing Manual can be located online at:  
<http://dhs.iowa.gov/sites/default/files/All-IV.pdf>



## **M. Resource Sharing Between Iowa Medicaid and Iowa Vocational Rehabilitation Services (IVRS)**

### **1. Resource Sharing for Employment Services**

People are more likely to succeed in employment when funding and services available through both IVRS and Medicaid are shared. Each program has limitations but together they can provide holistic support for someone with a disability who wants to find and keep community-integrated employment.

The following *Resource Sharing* document was developed between IVRS and the DHS/Iowa Medicaid Enterprise in January of 2015. This “cheat sheet” is the result of a collaborative effort by both agencies to satisfy the requirement each had to explore “comparable benefits and services” and address the “payer of last resort” issue.

By establishing this *Resource Sharing* document, IVRS and DHS, Iowa Medicaid have outlined their respective funding obligations when paying for Supported Employment Services (SES) for a mutual client served by both agencies. The document has been updated to reflect the new (2014) IVRS policy to fund the necessary employment services (including Supported Employment Services when needed) to help an eligible individual with a disability **under the age of 24** to get a community-integrated job paying at least minimum wage.

The *Resource Sharing* document also outlines procedural information for individuals on a DHS, Iowa Medicaid waiver waiting list who are eligible to be served by IVRS, including options for long-term follow-up services if waiver services are not immediately available.

Some additional items to be aware of:

- ◆ Individuals can receive state plan habilitation or waiver funded services (including employment services) during the same time period that IVRS is also providing services to them as long as the services provided through state plan habilitation or waiver do not duplicate the services provided by IVRS.



- ◆ When IVRS closes a case for someone enrolled in state plan habilitation or a waiver, the person may have a need for ongoing supports to maintain their competitive integrated employment. The IVRS counselor is expected to inform you in advance of the case closure date so that you can submit a timely request for prior authorization for the services that may be needed. **There should be no gap in the availability of supports.** A gap could jeopardize the person’s ability to maintain the person’s job; therefore, this should be avoided at all costs.

## 2. Resource Sharing Between DHS and IVRS for Supported Employment Services

This section explains how Supported Employment Services (SES) are funded for mutual job candidates who are eligible for both IVRS services and DHS state plan habilitation or waiver services. Funding braided between IVRS and DHS habilitation or waiver for SES depends on whether an individual is on or off a waiting list, their age, and the service responsibilities agreed to by each agency.

### a. SES for Individuals Under Age 24 (IVRS)

Effective November 13, 2014, for job candidates under age 24 who are eligible for both IVRS and DHS state plan habilitation or waiver and who require Supported Employment Services, IVRS implemented a *Memorandum of Agreement* with DHS to establish IVRS as the payer of first resort for individualized services necessary to obtain and stabilize in competitive integrated employment. Services can include any of the following:

Job Development	Customized Employment	Job Coaching**
<p><b>IVRS 15-minute units:</b>            Initial authorization: 160 units with one extension of 80 units, not to exceed 240 units</p> <p>Up to 40 hours with one extension of 20 hours, not to exceed 60 hours total</p>	<p><b>IVRS 15-minute units:</b>            as part of SES to negotiate with employer up to 40 units</p> <p>Up to ten hours</p>	<p><b>IVRS 15-minute units:</b>            based on the number of hours a job candidate works - to be negotiated between IVRS and team for up to a two-month period of time</p> <p>Up to 120 hours</p>

**There is no requirement** that people must get a job of at least 10 hours a week in order to receive services to obtain a job from IVRS. IVRS cases in which a job candidate works less than 10 hours a week require an explanation of why this individual cannot work more than 10 hours and supervisory review/approval prior to closure.

The MOA between DHS and IVRS is found on this link:  
[http://www.ivrs.iowa.gov/PolicyManual/MOA\\_IVRS\\_DHS.pdf](http://www.ivrs.iowa.gov/PolicyManual/MOA_IVRS_DHS.pdf)

NOTE: The agreement between IVRS and the Department of Education takes precedence over this DHS agreement for students in transition receiving SES under an IEP.

**b. SES for Individuals Aged 24 and Above (DHS/IVRS)**

Effective November 13, 2014, for job candidates aged 24 and above, the waiver pays for job development and job coaching. IVRS funds may pay for customized employment and employment services not listed (discovery, workplace readiness assessment, etc.). IVRS also supplements waiver funds providing job development as deemed necessary, such as when waiver funds end. This is in accordance with the *Memorandum of Agreement* with DHS and IVRS.

Job Development	Customized Employment	Job Coaching
<p><b>State Plan Habilitation or Waiver (T2018)</b></p> <p><b>15-minute units:</b>            Initial authorization: 160 units            Limit 240 units per calendar year</p>	<p><b>IVRS</b></p> <p><b>15-minute units:</b>            as part of SES to negotiate with employer up to 40 units            Up to ten hours</p>	<p><b>State Plan Habilitation or Waiver (H2025)</b></p> <p><b>Unit = One month</b></p> <p>Payment varies depending on amount of support needed:            Tier 0: Minimum 1 contact/ month            Tier 1: 2-8 hours support/ month            Tier 2: 9-16 hours support/ month            Tier 3: 17-24 hours support/ month            EXCEPTION: 25 or more hours support/month</p>



There is **no requirement** that people must get a job of at least 10 hours a week in order to receive services to obtain a job from IVRS. IVRS cases in which a job candidate works less than 10 hours a week require an explanation of why this individual cannot work more than 10 hours and supervisory review/approval prior to closure.

Additional SES information can be found in the 2015 *Menu of Services Manual* on this link:

<http://www.ivrs.iowa.gov/partners/CRP/CRPmanualDec24.docx>

**c. SES for IVRS-Eligible Individuals Waiting for Waiver**

A job candidate eligible for IVRS who is waiting for services from waiver can be served by IVRS.

Until waiver funds are available, IVRS may fund all SES employment services which may include job development, customized employment, and job coaching. (*See table below.*) Services for SES are authorized by IVRS until the time waiver funds become available. If or when that occurs, IVRS would cancel any unused authorizations for remaining services so that waiver funding could begin, except in IVRS cases involving SES for individuals under age 24.



**d. SES for IVRS-Eligible Individuals Ineligible for State Plan Habilitation or Waiver**

For IVRS-eligible job candidates who do not qualify for state plan habilitation or waiver, IVRS may fund all SES employment services which can include job development, customized employment, and job coaching. (See table below.)

Job Development	Customized Employment	Job Coaching
<p><b>IVRS</b>  <b>15-minute units:</b>            Initial authorization: 160 units with one extension of 80 units, not to exceed 240 units</p> <p>Up to 40 hours with one extension of 20 hours, not to exceed 60 hours</p>	<p><b>IVRS</b>  <b>15-minute units:</b>            as part of SES to negotiate with employer up to 40 units</p> <p>Up to ten hours</p>	<p><b>IVRS</b>  <b>15-minute units:</b>            based on the number of hours a job candidate works - to be negotiated between IVRS and team for up to a two-month period of time</p> <p>Up to 120 hours</p>

Identified source for long-term job coaching services, to the extent needed by the individual, is required for IVRS supported employment services. Funding (or sources) to provide these services can include county funding, natural supports, PASS, IRWE, MH worker, independent living, or other no-cost resources.

The source providing long-term job coaching, to the extent needed by the individual, is identified on the IVRS Plan for Employment (IPE) and SES Placement Agreement (Section IV. of Employment Analysis form). A plan for natural supports requires a detailed description of how the natural support will be trained and the agreement on how to connect with the long-term provider when difficulties arise requiring more continued involvement by the CRP.