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HOME- AND COMMUNITY-BASED SERVICES (HCBS) MANUAL TRANSMITTAL NO. 16-1

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Summary

The **HOME- AND COMMUNITY-BASED SERVICES (HCBS) MANUAL** is revised to align with current IA Health Link policies, procedures, and terminology.

Date Effective

January 1, 2016

Material Superseded

This material replaces the following pages from the **HOME- AND COMMUNITY-BASED SERVICES (HCBS) MANUAL**:

<u>Page</u>	<u>Date</u>
Chapter III	
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Additional Information

The updated provider manual containing the revised pages can be found at:
<http://dhs.iowa.gov/sites/default/files/HCBS.pdf>

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.



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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.

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 the Iowa Medicaid Enterprise (IME). The IME has the authority for the operation of the waiver programs including prior authorization of waiver.

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:

Waiver Type	Corresponding Iowa Administrative Code
AIDS/HIV	441 Iowa Administrative Code (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)



“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.

“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

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

"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.

"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.

“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.

“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.

“IME” means the Iowa Medicaid Enterprise.

“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.

“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 or service worker 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.

“ISIS” is the Iowa Department of Human Services’ *Individualized Services Information System*.

The purpose of ISIS 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.



“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 reasonable 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 service worker, 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.



“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 consumer’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.

“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.

3. Service Eligibility

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
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 being in need of nursing facility, skilled nursing facility, or hospital level of care or as being in need of care in an intermediate care facility for the intellectually disabled. The IME 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:

Waiver Type	Corresponding Iowa Administrative Code
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, the IME assigns the slot to the applicant. Once assigned, the service worker or case manager or integrated health home care coordination staff will participate in the assessment, level of care, and processes, unless the applicant is determined to be ineligible by either functional or financial assessment. If an applicant is granted waiver eligibility and is IHH or MCO enrolled, the IHH or MCO will be responsible for service planning.



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*. 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. 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				



Services by Program	AIDS/HIV	BI	CMH	EW	HD	ID	PD
Interim medical monitoring and treatment (IMMT)		X			X	X	
Mental health outreach				X			
Nursing	X			X	X	X	
Nutritional counseling				X	X		
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 (RBSCCL)						X	
Supported employment (SE)		X				X	
Transportation		X		X		X	X

6. Waiver Prior Authorization

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

The IME Medical Services Unit may request additional information from the service worker or 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.

7. 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 service worker, 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 Medicaid case manager, integrated health home, or Department service worker 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, or service worker, 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 annually to revise the service plan, at least annually or whenever there is a significant change in the items addressed in it member's needs or conditions.

8. 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 service worker, case manager or integrated health home coordinator.

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

The comprehensive person-centered plan:

- ◆ 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 and what 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.



a. Denial of Application

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
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. 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:

Waiver Type	Corresponding Iowa Administrative Code
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 participants 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

Elderly

Corresponding Iowa Administrative Code

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. The cost of approved assistive devices is not included in the monthly cap for services under the waiver. Devices include, but are not limited to:

- ◆ Long-reach brush
- ◆ Extra-long shoe horn
- ◆ 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:

Waiver Type

Brain injury

Corresponding Iowa Administrative Code

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.



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

Services by Program	AIDS/HIV	BI	EW	HD	ID	PD
Adult day care		X				
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. ISIS 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 CM/SW of the initial budget amount and any change to the monthly budget amount.



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 provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as:

- ◆ Assistance with acquisition, retention, or improvement in self-help;
- ◆ Socialization and adaptive skills that enhance social development; and
- ◆ Developing skills in performing activities of daily living and community living.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the member's person-centered plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Day habilitation services focus on enabling the member to attain or maintain the member's maximum potential and shall be coordinated with any needed therapies in the member's person-centered services and supports plan, such as physical, occupational, or speech therapy.

Day habilitation must be furnished in an integrated community setting.



Day habilitation is:

- ◆ Delivered in accordance with an approved comprehensive service plan which specifically identifies the specific skills, training, and assistance to be provided, and the amount and frequency with which it will be provided.
- ◆ Coordinated with any needed therapies in the member's comprehensive service plan, such as physical therapy, occupational therapy or speech therapy.
- ◆ Face-to-face skill development training and supports, such as:
 - Assistance with the acquisition, retention or improvement of self-help;
 - Socialization and adaptive skills that enhance activities of daily living; and
 - Social development and community participation.
- ◆ An organized program of activities designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice.
- ◆ Designed and delivered in a manner that is individualized and focused on enabling the member to attain or maintain the member's maximum potential.
- ◆ Provided documents in accordance with 441 IAC Chapters 77, 78, and 79.

Exclusions:

- ◆ Day habilitation services must be provided in an integrated community setting.
- ◆ Services shall not include vocational or prevocational services and shall not involve paid work.
- ◆ Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- ◆ Services shall not be provided simultaneously with other Medicaid-funded services.
- ◆ Supervision or protective oversight.
- ◆ Indirect services such as meetings, documentation or collateral contacts.
- ◆ 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.

EXCEPTION: 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.

12. Environmental Modification and Adaptive Devices

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
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 case manager 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:

Waiver Type	Corresponding Iowa Administrative Code
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



15. Financial Management Service (FMS)

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
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*. Click [here](#) to view the form online.



The FMS shall perform all of the following services:

- ◆ Receive Medicaid funds in an electronic transfer
- ◆ Process and pay invoices for approved goods and services included in the individual budget
- ◆ Enter the individual budget into the Web-based tracking system chosen by the Department and enter expenditures as they are paid
- ◆ Provide real-time individual budget account balances for the member, the independent support broker, and the Department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday)
- ◆ Conduct criminal background checks on potential employees pursuant to 441 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 that hourly wages comply with federal and state labor rules.
 - Collecting and processing timecards.
 - Withholding, filing, and paying federal, state, and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 - Computing and processing other withholdings, as applicable.
 - Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 - Preparing and issuing employee payroll checks.
 - Preparing and disbursing IRS forms W-2 and W-3 annually.
 - Processing federal advance earned income tax credit for eligible employees.
 - Refunding over-collected FICA, when appropriate.
 - Refunding over-collected FUTA, when appropriate.



Services shall be included in the member's service plan and shall exceed the Medicaid state plan services. Services shall be performed following prior Department 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 or service worker shall submit the certificate of medical necessity, the service plan and the contract, invoice or quotations from the providers to the IME 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.



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:

Waiver Type	Corresponding Iowa Administrative Code
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 child care 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:

Waiver Type	Corresponding Iowa Administrative Code
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 on the basis of 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:

Waiver Type	Corresponding Iowa Administrative Code
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)



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.

Prevocational services may be furnished in any of a variety of community integrated settings.

Prevocational services do not include services that are otherwise available to the member through a state or local education agency or vocational rehabilitation services.

Documentation is maintained in the service plan that justifies why services are not accessed through IVRS.

29. Residential-Based Supported Community Living Services

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Intellectual disability	441 IAC 78.41(10)

Residential-based supported community living services (RBSCCL) 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.

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

RBSCCL 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 RBSCCL.

The maximum number of units of RBSCCL 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 medical equipment can be covered when it is:

- ◆ Identified in the member's approved service plan documented in the Individualized Services Information System (ISIS).
- ◆ 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:

Waiver Type	Corresponding Iowa Administrative Code
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 Long-Term Care 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 available per member are as follows:

- ◆ **BI or ID:** 365 daily units per state fiscal year, except a leap year, when 366 daily units are available.
- ◆ **BI or ID:** 11,315 15-minute units per state fiscal year, except a leap year, when 11,346 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.
- ◆ **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.



Transportation services may be provided for members:

- ◆ To conduct business errands and essential shopping,
- ◆ To travel to and from work or day programs (BI, 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.

This is the same criteria for transportation when provided as part of the SCL service. A provider may not simultaneously bill for SCL services and transportation (the service) when the provider is including the cost of transportation in the SCL rate. 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 \$1,750 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. PROVIDER ENROLLMENT WITH IOWA MEDICAID

1. Certification and Enrollment of New Providers

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

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

The IME 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.

Upon request, an application packet will be sent containing:

- ◆ 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
- ◆ Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 135C.33(5)“a”(1) before employment of a staff member who will provide direct care.



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

The IME 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 the 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 IME 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.



- ◆ **Health and disability waiver.** Respite, agency CDAC, IMMT, adult day care, counseling;
- ◆ **Physical disability waiver.** Agency CDAC;
- ◆ **Habilitation services.** Day habilitation, home-based habilitation, prevocational habilitation, supported employment habilitation.

In addition, supported community living (pursuant to 441 IAC 77.37(249A) providers must meet the outcome-based standards set forth below. Respite and supported employment providers must meet the organizational standards in Outcome 1.

Organizational outcome-based standards for HCBS ID and BI providers are as follows:

- ◆ Outcome 1:
 - The organization demonstrates the provision and oversight of high-quality supports and services to members.
 - The organization demonstrates a defined mission commensurate with member's needs, desires, and abilities.
 - The organization establishes and maintains fiscal accountability.
 - The organization has qualified staff commensurate with the needs of the members they serve. These staff demonstrate competency in performing duties and in all interactions with members.
 - The organization provides needed training and supports to its staff. This training includes at a minimum:
 - Member rights
 - Confidentiality
 - Provision of member medication
 - Identification and reporting of child and dependent adult abuse
 - Member support needs



3. Assisted Living Providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
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:

Waiver Type	Corresponding Iowa Administrative Code
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.



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.



23. 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 IME 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.



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 IME 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.



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 should include a copy of the Notice of Decision 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 dates 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, service workers, 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.

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 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 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 Incidents

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 service worker, 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 by the use of 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 the Individualized Services Information System (ISIS) for follow-up by the case manager, service worker 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.

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:

Waiver Type	Corresponding Iowa Administrative Code
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 or service worker must assign client participation to one or more of the wavier services listed in the ISIS 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 IME the difference in this amount by subtracting off the amount of client participation.

For members enrolled for fee-for-service, the case manager or service worker 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 or service worker 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:

Waiver Type	Corresponding Iowa Administrative Code
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 service worker or 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:

Waiver Type	Corresponding Iowa Administrative Code
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.



- ◆ **Daily rates** are based on the actual cost per unit of the current period reported on *Schedule D-3* of form 470-0664 for each site, the calculated base rate from the previous year, or the maximum reimbursement rate.
 - An inflation factor will be added to the cost per unit of the current and previous reporting period, not to exceed the maximum reimbursement rate.
 - The IME Medical Services Unit may grant variations when cost-effective and in accordance with the service plan.
 - No actual cost per unit rates will be set based on the annual cost report if the period reported is less than six months.

Projected rates will continue to be effective for providers with less than six months of actual cost data. Supported community living daily site rates that have been revised since the initial rate projection continue to be in effect if so noted on the submitted form 470-3449, *HCBS Supplemental Schedule D-4*.

K. PROCEDURE CODES AND NOMENCLATURE

Providers must use procedure codes to bill for waiver services. Use the following procedure codes to identify waiver services in the waiver service plan.

Service	AIDS/ HIV	BI	CMH	Elderly	HD	ID	PD	Modifier
Adult day care; half day	S5101	S5101		S5101	S5101	S5101		None
Adult day care; full day	S5102	S5102		S5102	S5102	S5102		None
Adult day care; extended day	S5105	S5105		S5105	S5105	S5105		None
Adult day care; hourly	S5100	S5100		S5100	S5100	S5100		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



Service	AIDS/ HIV	BI	CMH	Elderly	HD	ID	PD	Modifier
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						T2020		None
Day habilitation; 15 minute unit						T2021		None
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



Service	AIDS/ HIV	BI	CMH	Elderly	HD	ID	PD	Modifier
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
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



Service	AIDS/ HIV	BI	CMH	Elderly	HD	ID	PD	Modifier
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); 15 minute unit	T1030			T1030	T1030	S9123 hour		
Nursing (LPN); 15 minute unit	T1031			T1031	T1031	S9124 hour		
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
Prevocational services (daily)		T2014				T2014		None
Prevocational services; per hour		T2015				T2015		None
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



Service	AIDS/ HIV	BI	CMH	Elderly	HD	ID	PD	Modifier
Supported employment (enhanced job search); 15 minute unit		H2019				H2019		None
Supported employment (job coaching); 15 minute unit		H2025				H2025		None
Supported employment (enclave); 15 minute unit		H2023				H2023		None
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



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L. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for waiver providers are billed on the *Claim for Targeted Medical Care*, form 470-2486. Click [here](#) to view the form online.

Copies of this form may be obtained from IME Provider Services at (800) 338-7909 or, in the Des Moines area at (515) 256-4609, or at the bottom of the IME Provider Services webpage at <http://dhs.iowa.gov/ime/Providers/claims-and-billing/ClaimsPage>. 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>