Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Adult Day Care
Statutory Service	Case Management
Statutory Service	Consumer Directed Attendant Care - Skilled
Statutory Service	Prevocational Services
Statutory Service	Respite
Statutory Service	Supported Employment
Supports for Participant Direction	Financial Management Service - Supports the self-direction option
Other Service	Behavioral Programming
Other Service	Consumer Directed Attendant Care (CDAC) unskilled
Other Service	Family Counseling and Training Services
Other Service	Home and Vehicle Modification
Other Service	Independent Support Broker - Consumer Choices Option
Other Service	Interim Medicial Monitoring and Treatment (IMMT)
Other Service	Personal Emergency Response System or Portable Locator System
Other Service	Self Directed Community Support and Employment
Other Service	Self Directed Goods and Services
Other Service	Self Directed Personal Care - Consumer Choices Option
Other Service	Specialized Medical Equipment
Other Service	Supported Community Living
Other Service	Transportation

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Adult Day Health

Alternate Service Title (if any):
Adult Day Care

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

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

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

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on regular or intermittent basis in a day care center. Meals provided as part of these services shall not constitute a full nutritional day. These services are contracted through the individual county where the provider operates.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Adult day services has an upper rate limit if there is no Veterans Administration contract. The rates are subject to change on a yearly basis. A unit of service is 15 minutes, a half day (1 to 4 hours), a full day (4.25 to 8 hours) or an extended day (8.25 to 12 hours). Transportation is not a required element of adult day services but if the cost of transportation is provided and charged to Medicaid, the cost of transportation must be included in the adult day health rate. The case manager is responsible for authorizing services based on member need and monitors the service to assure that needed services are provided. If transportation to and from the ADC is needed (based on the ADC providers transportation), the CM will authorize and monitor the authorized transportation as needed.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Agencies that are certified by the Department of Inspections and Appeals

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:
Agency

Provider Type:
Adult Day Care Agencies that are certified by the Department of Inspections and Appeals

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Agency that is certified by the Department of Inspection and Appeals as being in compliance with the standards for adult day services located at 481 Iowa Adminsiateive Code - Chapter 70.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The Iowa Deparmtent of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Verification based on length of certification

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Case Management
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

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

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

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.
a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).
b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.
c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.
d. Members who are at the ICF/MR level of care whose county has voluntarily chosen to participate in the HCBS brain injury waiver are eligible for targeted case management and, therefore, are not eligible for case management as a waiver service.

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.

Targeted population means people who meet one of the following criteria:
1. An adult who is identified with a primary diagnosis of mental retardation, chronic mental illness or developmental disability; or
2. A child who is eligible to receive HCBS mental retardation waiver or HCBS children's mental health waiver services according to 441—Chapter 83.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Payment for case management may not be made until the member is enrolled in the waiver. Payment can also only be made if case management activity is performed on behalf of the member during the month. Case Managers are required to have at least quarterly face to face contacts.
A unit of service is one 15 minute increment. Transitional case management servcies are not aviable under the Brain Injury waiver, but are provided as a State Plan service to Brain Injury waiver members for 30 days prior to discharge to coordiante discharge planning, this services may not duplicate the efforts of the facility's discharge planner.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency - Provider
Agency	Agency- County
Agency	Agency - DHS

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Agency - Provider
Provider Qualifications
License *(specify):*
An Agency that meets Iowa Administrative code 441.24 for case management services. The Agency submits their certification papers along with their provider application in order to be enrolled to provide case management
An Agency that is accredited through the Commission on Accreditation of Rehabilitation Facilities for Case Management services. They must attach a current certification and most recent CARF survey report.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services- Iowa Medicaid Enterprise
Frequency of Verification:
Verified based on length of certification

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Agency- County
Provider Qualifications
License *(specify):*

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services Iowa Medicaid Enterprise
Frequency of Verification:
Verified based on length of certification

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Agency - DHS
Provider Qualifications
License *(specify):*

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services Iowa Medicaid Enterprise
Frequency of Verification:
Verification based on length of certification

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Personal Care
Alternate Service Title (if any):
Consumer Directed Attendant Care - Skilled

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

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

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

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Skilled Consumer Directed Attendant Care service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. Services may be provided in the member's home or other location as appropriate based on the individual member's need.
The licensed nurse or therapist shall retain accountability for actions that are delegated.
The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.
(1) Tube feedings of members unable to eat solid foods.
(2) Intravenous therapy administered by a registered nurse.
(3) Parenteral injections required more than once a week.
(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.
(8) Colostomy care.
(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.
(10) Postsurgical nursing care.
(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
(12) Preparing and monitoring response to therapeutic diets.
(13) Recording and reporting of changes in vital signs to the nurse or therapist.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit of service is 15 minutes provided by an individual or an agency.
Each service shall be billed in whole units.
CDAC may be provided to a recipient of in-home health related care services, but not at the same time. There is an upper limit for both aency and individual providers. These are subject to change on a yearly basis.
d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the

attendant care services to be provided.
e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

The state will revise its current coding system by establishing new procedure codes for skilled and unskilled CDAC that will enable the state to report CDAC (skilled) and CDAC (unskilled)costs separately. Beginning December 01, 2009, Case Mangers will begin incremental implmementation of the new procedure codes for skilled and unskilled CDAC services. The new procedure codes will be entered into the member's service plan as the service plan changes or as a new service plan begins. The goal of this phased in process is to have all service plans utilizing independent procedure codes for skilled and unskilled CDAC services by December 01, 2010.

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

Participant-directed as specified in Appendix E
Provider managed

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

Legally Responsible Person
Relative
Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Chore Provider
Agency	Adult Day Service provider
Agency	Home Care provider
Agency	Community Action Agency
Individual	Individual
Agency	Home Health Agency
Agency	Assisted Living Program
Agency	Supported Community Living provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:
Agency
Provider Type:
Chore Provider
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
Verification of Provider Qualifications

Entity Responsible for Verification:
Iowa Department of Human Services Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:
Agency
Provider Type:
Adult Day Service provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Adult Day Service providers that meet the conditions of particiaption for adutl day care providers as specified at 441-subrule 77.30(3), 77.33(1), 77.34(7), or 77.30(20) and that had provided a point in time letter of notification from the department on aging or the area agency on aging stating that the adult day service provider meets the requiremetns of the department on aging rules in 331 IAC chapter 25.

Verification of Provider Qualifications
Entity Responsible for Verification:
The Iowa Deparmtent of Human Services, the Iowa Mediciad Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:
Agency
Provider Type:
Home Care provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135),

and
641—80.7(135).

Verification of Provider Qualifications

Entity Responsible for Verification:
Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:
Agency

Provider Type:
Community Action Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Community action agencies as designated in Iowa Code section 216A.93.

Verification of Provider Qualifications

Entity Responsible for Verification:
Iowa Departmet of Human Services Iowa Medicaid Enterprise

Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:
Individual

Provider Type:
Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
An individual who contracts with the consumer to provide attendant care service and who is:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.
(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

Verification of Provider Qualifications

Entity Responsible for Verification:
Iowa Department of Human services, Iowa Medicaid Enterprise

Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:
Agency

Provider Type:
Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Home health agencies which are certified to participate in the Medicare program.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:
Agency

Provider Type:
Assisted Living Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Assited Living Programs that are voluntarily accredited or certified by the Department on Aging.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:
Agency
Provider Type:
Supported Community Living provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Providers certified under an HCBS waiver for supported community living.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services Ioa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Prevocational Services
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

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

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

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Prevocational services are services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process.
Individuals receiving prevocational services must have employment-related goals in their person-centered services and supports plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the optimal outcome of prevocational services.
Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills; Examples include, but are not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.
Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services provided under the waiver. Prevocational may be furnished in any of a variety of settings in the community other than the person's private residence, the provider administrative offices or other settings that have the effect of isolating the member form the greater community.

When transportation is provided between the participants' place of residence and the Prevocational service site (s) is provided as a component part of this service the cost of transportation is included in the rate paid to providers of prevocational services.
The cost of meals is not an allowable cost for Prevocational services. Documentation is maintained in the file of each member that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Transportation between the member's residence and the pre-vocational services is not a component of the pre-vocational service rate paid to pre-vocational providers.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The unit of service may be a hour or a full day (4.25 to 8 hours). There is an upper rate limit that is subject to change on a yearly basis. The first line of prevention of duplicative billing for similar types of day programs (Day Habilitation, pre-vocational, supported employment and Adult day care) is the member's case manager. The case manager is responsible for the authorization and monitoring of services in a member's plan of care. If the case manager authorizes similar services during the same time period, they are responsible to assure that the services are being delivered as ordered. The ISIS system generates a review report to assist the case manager. The report identifies all services that have been billed for a specific time period (ex. one month). The case manager is able to view the service billed to the individual member, the amount of the service billed and the provider. The case manager is able to compare what has been billed by the provider to what is ordered in the plan of care. The department also conducts post audit reviews of providers to review the billing of providers to assure that the services provided have documentation to support the billing.

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

Participant-directed as specified in Appendix E
Provider managed

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

Legally Responsible Person
Relative
Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Providers of prevocational services must be accredited by one of the following:
a. The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.
b. The Council on Quality and Leadership.

Verification of Provider Qualifications
Entity Responsible for Verification:
The Iowa Deparmtent of Human Services
Frequency of Verification:
Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Respite
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would
provide during that time period. The purpose of respite care is to enable the member to remain in the member's current living situation
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The following limitations apply:
a.Services provided outside the member's home shall not be reimbursable if the living unit where the respite is provided is reserved for another person on a temporary leave of absence.
b.Staff-to-consumer ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
c. A unit of service is 15 minutes. There is an upper limit set for rates based on provider type that is subject to change on a yearly basis.
d. The service shall be identified in the member's individual comprehensive plan.
f. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS BI waiver supported community living services, Medicaid nursing, or Medicaid BI home health aide services.
g. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the member is attending a camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
h. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A).
i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
j. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care provided outside of the member's home. This may include Intermediate Care Facilities for persons

with Intellectual Disabilities (ICF/ID, residential care facilities for persons with Intellectual Disabilities (RCF/ID), licensed foster care homes, Camps accredited by the American Camping Association, and hotels and motels. Hotels and motels are used based on individual need, the FFP is considered to be included within the rate paid to the respite provider.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Facility - Nursing Facility
Agency	Agency
Agency	Camps
Agency	Home Health
Agency	Facility - Residential Care Facility
Agency	Facility ICF/ID
Agency	Group Living Foster Care Facility
Agency	Child Care Facility
Agency	Assisted Living Programs
Agency	Facility - Hospital
Agency	Home Care Agency
Agency	Adult Day Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Facility - Nursing Facility
Provider Qualifications
License *(specify)*:
Liscensed by the Department of Inspections and Appeals.
Certificate *(specify)*:

Other Standard *(specify)*:
Enrolled as Medicaid providers
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Agencies certified by the department to provide respite in a member's home that meet the organizational standards set forth in 441 IAC 77.39(1), 77.39(3)through 77.39(7)
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Camps
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Camps certified by the American Camping Association.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Home Health
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Home Health Agency certified by Medicare
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The Iowa Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Facility - Residential Care Facility
Provider Qualifications
License *(specify):*
RCF liscensed by the Department of Inspections and Appeals
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Facility ICF/ID
Provider Qualifications
License *(specify):*
Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) liscensed by the Department of Inspections and Appeals.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Group Living Foster Care Facility
Provider Qualifications
License *(specify):*
Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to IAC 441—Chapter 109.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services Iowa Mediciad Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:
Agency
Provider Type:
Child Care Facility
Provider Qualifications
License *(specify):*
Child Care Facilities that are defined as child care centers, preschools, or child development homes registered pursuant to 441 IAC chapter 110.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Assisted Living Programs
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certified by the Department of Inspections and Appeals
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The Iowa Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Facility - Hospital
Provider Qualifications
License *(specify):*
Liscensed by the Department of Inspections and Appeals
Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an Iowa Medicaid provider.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Home Care Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Home care agencies that meet the Home Care requirements set forth in IAC 641-80.5(135), 641-80.6 (1350 and 641-80.7 (135) or certified by Medicare as a Home Health agency
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Adult Day Care
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certified by the Department of Inspections and Appeals as being in compliance with the standards for adult day services programs adopted by the departmentof elder affairs at 321 - Chapter 24.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services Iowa Mediciad Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Supported Employment
Alternate Service Title (if any):

HCBS Taxonomy:

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

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Supported Employment -Individual Employment Support services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Supported employment services can be provided through many different service models. Some of these models can include evidence-based supported employment for individuals with mental illness, or customized employment for individuals with significant disabilities. States may define other models of individualized supported employment that promote community inclusion and integrated employment.
Supported employment individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, asset development and career advancement services, and other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting. Supported employment individual employment supports is not intended for people working in mobile work crews of small groups of people with disabilities in the community. That type of work support is addressed in the core service definition for Supported Employment Small Group employment support.
Transportation between the participant's place of residence and the employment site is a component part of supported employment individual employment supports and small group support services and the cost of this transportation is included in the rate paid to providers of supported employment individual employment supports services.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

Individual placements are the preferred service model. Covered services are those listed in paragraphs "a" and "b" that address the disability-related challenges to securing and keeping a job.
a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in 441—subrule 83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the member's case manager must approve the services. Available components of activities to obtain a job are as follows:
(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include:
1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.
2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.
3. Customized job development services specific to the member.
(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.87(249A). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of

employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:
1. Developing relationships with employers and providing leads for individual members when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.
(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's
employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:
1. Job opening identification with the member.
2. Assistance with applying for a job, including completion of applications or interviews.
3. Work site assessment and job accommodation evaluation.
b. Supports to maintain employment.
(1) Covered services provided to or on behalf of the member associated with maintaining competitive paid employment are the following:
1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assisting the member to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Consumer-directed attendant care services as defined in subrule 78.41(8).
6. Assistance with time management.
7. Assistance with appropriate grooming.
8. Employment-related supportive contacts.
9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
10. On-site vocational assessment after employment.
11. Employer consultation.
(2) Services for maintaining employment may include services associated with sustaining members in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.
(3) A unit of service is 15 minutes.
(4) A maximum of 160 units may be received per week.

Federal Financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program
2. Payments that are passed through to users of supported employment programs
3. Payments for training that is not directly related to an individual's supported employment program

Supported Employment Small Group employment support (Enclave) are services and training activities provided in regular business, industry and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Supported employment small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small group employment support does not include vocational services provided

in facility based work settings.
Supported employment small group employment supports may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits support, training and planning transportation and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

Transportation between the participant's place of residence and the employment site is a component part of supported employment individual employment supports and small group support services and the cost of this transportation is included in the rate paid to providers of supported employment individual employment supports services.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit of service for obtaining a job is one job placement that the member holds for 30 consecutive calendar days or more.
A unit of service for employer development is one job placement that the member holds for 30 consecutive calendar days or more.
A unit of service for enhanced job search activities is one hour. A maximum of 26 units may be provided in a 12 month period.
A unit of service for maintaining employment for an individual or group is 15 minutes, A maximum of 160 units may be received per week.
There are upper rate limits that are subject to change on a yearly basis.

The following requirements apply to all supported employment services:
(1) Employment-related adaptations required to assist the member within the performance of the member's job functions shall be provided by the provider as part of the services.
(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.
(3) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.
(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.
(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) shall be maintained in the provider file of each member.
All services shall be identified in the member's service plan maintained pursuant to rule 441—83.67(249A).
The following services are not covered:
1. Services involved in placing or maintaining members in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or
4. Individual advocacy that is not member specific.

Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other

Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Providers responsible for the payroll of consumers shall have policies that include, but are not limited to:
(1) Consumer vacation, sick leave and holiday compensation.
(2) Procedures for payment schedules and pay scale.
(3) Procedures for provision of workers' compensation insurance.
(4) Procedures for the determination and review of commensurate wages.
(5) Both state and federal department of labor requirements.
Other Standard *(specify)*:
b. The department shall certify only public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Every four years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Management Service - Supports the self-direction option

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope)*:

The Financial Management Service (FMS) is necessary for all members choosing the self-direction option, and is available only to those who self direct. The FMS is enrolled as a Medicaid Provider. The FMS will receive Medicaid funds in an electronic transfer and will pay all service providers and employees electing the self-direction option. The FMS services are provided to ensure that the individualized budgets are managed and distributed according to the budget developed by each member and to facilitate the employment of service workers. For those members who self-direct, the FMS will:

· Establish and manage members and directly hired workers documents and files
· Manage and monitor timesheets and invoices to assure that they match the written budget
· Provide monthly and quarterly status reports for the Department and for the member that include a summary of
expenditures paid and amounts of budgets that are unused.
· Assist members in understanding their fiscal/payroll related responsibilities
· Assist members in completing required federal, state and local tax and insurance forms
· Assist members in conducting criminal background checks on potential employees, if requested
· Assist members in verifying service workers citizenship or alien status
· Prepares and disburses payroll if a program member hires workers. Key employer-related tasks include:
· Verifying that service workers' hourly wages are in compliance with federal and state Department of Labor rules;
· Collecting and processing services workers' timesheets;
· Withholding, filing and paying federal, state and local income, Medicare and Social Security (FICA), federal (FUTA) and
state (SUTA) unemployment and disability insurance (as applicable) taxes'

· Computing and processing other benefits, as applicable;
· Preparing and issuing service workers' payroll checks;
· Refunding over collected FICA, when appropriate (Fiscal/Employer Agent)
· Refunding over collected FUTA, when appropriate (Fiscal/Employer Agent)
· Processing all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal,
state or local laws, and
· Prepare and disburse IRS Forms W-2 and W-3 annually.
· Process and pay invoices for approved goods and services included in program members' budgets;
· Assists in implementing the state's quality management strategy related to FMS
· Establish an accessible customer service system and communication path for the member and the Individual Support Broker
· Provide monthly statements of Individual Budget account balances to both the Individual Support Broker and the member
· Provide real time Individual Budget account balances, at a minimum during normal business hours (9-5, Monday –Friday)
· Ability to interface with the tracking system chosen by the Iowa Department of Human Services
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The monthly fee for financial management services is subject to an upper limit which is subject to change on a yearly basis.

A member who elects the consumer choices option may purchase the following services and supports, which shall be provided in the member's home or at an integrated community setting:
(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community.
(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration.
(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the member's service plan. The item or service shall decrease the member's need for other Medicaid services, promote the member's inclusion in the community, or increase the member's safety in the community.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Service

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Service - Supports the self-direction option

Provider Category:
Agency
Provider Type:

Financial Management Service
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Financial Institution that meets the following qualifications.
a. The financial institution shall either:
(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union
division of the Iowa department of commerce; or
(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Human Services Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Behavioral Programming

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Behavioral Programming consists of individually designed strategies to increase the member's appropriate behaviors and decrease the member's maladaptive behaviors, which have interfered with the members ability to remain in the community. Behavioral programming consists of:
1. A complete assessment of both appropriate and maladaptive behaviors
2. Development of a structured behavioral intervention plan which should be identified in the Individual Treatment Plan.
3. Implementation of the behavioral intervention plan.
4. On-going training and supervision to caregivers and behavioral aides.
5. Periodic reassessment of the plan.

Types of appropriate behavioral programming include but are not limited to : clinical redirection, token economies, reinformcement, extinction, modeling and over-learning.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit of service is 15 minutes. There is an upper rate limit for this service which is subject to change on a yearly basis.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Aide Provider
Agency	Hospice Provider
Agency	Mental Health Center
Agency	Brain Injury Waiver Providers
Agency	Mental Health Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:
Agency
Provider Type:
Home Health Aide Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Human Services, The Iowa Medicaid Enterprsie
Frequency of Verification:
Verification is based on length of certification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:
Agency
Provider Type:
Hospice Provider
Provider Qualifications
License *(specify):*
Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53
Certificate *(specify):*
Agencies which are certified to meet the standards under the Medicare program for hospice programs.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Human Services, The Iowa Medicaid Enterprise
Frequency of Verification:
Verification is based on length of certification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:
Agency
Provider Type:
Mental Health Center
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24,

Divisions
I and III.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Verification based on length of certification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:
Agency
Provider Type:
Brain Injury Waiver Providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers and each of their staff members involved in direct consumer service must have training regarding or experience with consumers who have a brain injury, with the exception of providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under.
Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Human Services, The Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:
Agency
Provider Type:
Mental Health Service Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Department of Human Services, The Iowa Medicaid Enterprise

Frequency of Verification:
Verficiation is based on length of certification

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Consumer Directed Attendant Care (CDAC) unskilled

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. The service activities may include helping the member with any of the following nonskilled service activities:
(1) Dressing.
(2) Bath, shampoo, hygiene, and grooming.
(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.
(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.
(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.
(6) Housekeeping services which are essential to the member's health care at home.
(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.
(8) Wound care.
(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
(10) Cognitive assistance with tasks such as handling money and scheduling.
(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.
(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit of services is one hour , or one 8 to 24 hour day provided by an individual or an agency. Services are billed in whole units. There are upper rate limits whcih are subject to change on a yearly basis.

The first line of prevention of duplicative billing for similar types of services, such as home helath aide, is the member's case manager. The case manager is responsible for the authorization and monitoring of services in a member's plan of care. If the case manager authorizes similar services, they are responsible to assure that the services are being delivered as ordered. The ISIS system generates a review report to assist the case manager. The report identifies all services that have been billed for a specific time period (ex. one month). The case manager is able to view the service billed to the individual member, the amount of the service billed and the provider. The case manager is able to compare what has been billed by the provider to what is ordered in the plan of care. The department also conducts post audit reviews of providers to review the billing of providers to assure that the services provided have documentation to support the billing.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Chore provider
Agency	Home Care provider
Agency	Supported Community Living Provider
Agency	Assisted Living provider
Individual	Individual

Provider Category	Provider Type Title
Agency	Adult Day Care provider
Agency	Community Action Agency
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:
Agency
Provider Type:
Chore provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Human Services Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:
Agency
Provider Type:
Home Care provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).
Verification of Provider Qualifications
Entity Responsible for Verification:

Iowa DHS- Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:
Agency
Provider Type:
Supported Community Living Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers certified under an HCBS waiver for supported community living.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Human Services Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:
Agency
Provider Type:
Assisted Living provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Assisted living programs certified by the department of inspections and appeals
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Human Services Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
An individual who contracts with the consumer to provide attendant care service and who is:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.
(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa DSH - Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:
Agency
Provider Type:
Adult Day Care provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Adult day care providers that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Human Service Iowa Medicaid Enterprise

Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:
Agency
Provider Type:
Community Action Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Community action agencies as designated in Iowa Code section 216A.93.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Human Services
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Home health agencies which are certified to participate in the Iowa Medicare program
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa DHS - Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Family Counseling and Training Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope)*:

Family Counseling and training services are face to face mental health services provided to the member and family with whom the member lives, who routinely provide care to the member to increase the member's or family member's capabilities to maintain and care for the member in the community. Counseling may include helping the member or the member's family in a crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of the brain injury. It may include the use of treatment regimes as specified in the individual treatment plan. Periodic training updates may be necessary to safely maintain the member in the community.

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

A unit of service is one 15 minute increment for individual counseling.

A unit of service is one hour for group counseling.

There is an upper rate limit that is subject to change on a yearly basis.

Payment for group counseling is based on a group rate divded by six or the actual number of members participating in the group if the number of participants exceeds six members.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person
Relative
Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Mental Health Service Provider
Individual	Hospice Provider
Individual	Qualified Brain Injury Professional
Agency	Community Mental Health Centers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:
Agency
Provider Type:
Mental Health Service Provider
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Providers accredited under the mental health service provider standards established by the MH/DD commission set forth in 441 IAC Chapter 24, Divisions I and IV, and employ staff to provide family counseling and training that meet the definition of qualified brain injury professional as set forth in rule 441-83.81(249A)

Verification of Provider Qualifications
Entity Responsible for Verification:
The Iowa Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Verification is based on the length of certification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:
Individual
Provider Type:
Hospice Provider
Provider Qualifications
License *(specify)*:

Providers liscensed and meeting the hospice standards and requirements set forth in the Deprtment of Inspection and Appeals rules IAC 481- chapter 53 or

Certificate *(specify):*

Providers certified to meet the standards under Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441 83.81(249A)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services , the Iowa medicaid Enterprise

Frequency of Verification:

Verification is based on length of certification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Individual

Provider Type:

Qualified Brain Injury Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meet the definition of qualified brian injury professional as set forth in rule IAC 441- 83.81 (249A)

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Agency

Provider Type:

Community Mental Health Centers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers certified as Community Mental Health Centers established by the MH/DD commission set forth in 441 IAC Chpater 24, Divisions I and II, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441-83.81(249A)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

verification based on the length of certification

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home and Vehicle Modification

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Covered home and vehicle modifications are those physical modifications to the member's home or vehicle listed below that directly address the member's medical or remedial need. Covered modifications must be

necessary to provide for the health, welfare, or safety of the member and enable the member to function with greaterindependence in the home or vehicle.

Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle,such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded. Purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle are excluded. Upkeep and maintenance of the modifications are included.

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

There is an annual limit established for this service which is subject to change on a yearly basis.

Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the member.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services covered under durable medical equipment or specialized medical equipment.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Business
Agency	Provider
Agency	Agency

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Community Business
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Human Services, the Iowa Mediciad Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical

disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:
Every four years

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Providers certified to participate as supported community living service providers under the mental retardation or brain injury waiver.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:
Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Independent Support Broker - Consumer Choices Option

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2: **Sub-Category 2:**

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

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

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Independent Support Brokerage service is necessary for all members who chose the self-direction option. This is a service that is included in the member's Budget. The Independent Support Brokerage will be chosen and hired by the member. The ISB will work with the member to guide them through the person centered planning process and offer technical assistance and expertise for selecting and hiring employees and/or providers and purchasing supports.

The independent support broker shall perform the following services as directed by the member or the member's representative:
(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
(3) Complete the required employment packet with the financial management service.
(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
(7) Assist the member with negotiating with entities providing services and supports if requested by the member.
(8) Assist the member with contracts and payment methods for services and supports if requested by the member.
(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is necessary for members who choose the self-direction option at a maximum of 26 hours a year. When a member first initiates the self-direction option, the Independent Support Broker will be required to meet with the member at least monthly for the first three months and quarterly after that. If a member needs additional support brokerage service, the member will need prior authorization from the state. There will be a maximum rate per hour limit.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person
Relative
Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Support Broker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Independent Support Broker - Consumer Choices Option

Provider Category:
Individual
Provider Type:
Individual Support Broker
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
All Independent Support Brokers must be at least 18 years of age. To avoid conflict of interest, the Independent Support Broker cannot be a current service provider for the member. They will be required to successfully complete Independent Support Broker Certification. In addition they will be required to complete a criminal background check. The information obtained from the criminal background checks will be shared with the member to assist the member with making informed decisions whether to hire a potential Independent Support Broker.

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services- Iowa Medicaid Enterprise
Frequency of Verification:
Once initially trained, the Individual Support Broker is placed on a Independent Support Brokerage registry that is maintained at the Iowa Department of Human Services Iowa Medicaid Enterprise. The Independent Support Broker will be responsible for attending one support broker training a year held at the HCBS regional meetings

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

Service Title:

Interim Medicial Monitoring and Treatment (IMMT)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope)*:

Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the member's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

Service requirements of Interim medical monitoring and treatment services include:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

(4) Be in need as ordered by a physician

(5) Be monitored to assure it is not used as childcare.

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

Interim Medical Monitoring treatment services can not duplicate any regular Medicaid or waiver services, including EPSTD services, provided under the State plan. Documenation is maintained in the file of each indivdiaul receiving this service, that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA *20 U.S.C. 1401 et seq.

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

A maximum of 12 one hour units are avaiable per day. The is an upper rate limit for the service which is subject to change on a yearly basis.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person
Relative
Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interim Medicial Monitoring and Treatment (IMMT)

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Home Health agencies certified to participate in the Medicare program.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Humans Services Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interim Medicial Monitoring and Treatment (IMMT)

Provider Category:
Agency
Provider Type:
Supported Community Living provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Supported community living providers certified according to subrule 77.37(14) or 77.39(13).
Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Human Services, Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interim Medicial Monitoring and Treatment (IMMT)

Provider Category:
Agency
Provider Type:
Child Care Facility
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Humans Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Personal Emergency Response System or Portable Locator System

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

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

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

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency. The necessary components of a system are:
1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability. The required components of the portable locator system are:
1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

Provider staff are responsible for training members regarding the use of the system; the cost of this service is included in the charges for installation or monthly fee, depending upon how the provider structures their fee schedule. If necessary, case managers would also assist members in understanding how to utilize the system.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit of service is a one time installation fee or month of service. Maximum units per state fiscal year shall be one initial installation and 12 months of service. The member's plan of care will address how the member's health care needs are met. Services must be authorized in the service plan. The Case Manager will monitor the plan.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System or Portable Locator System

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per
week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency
administrator to whom authority and responsibility for overall agency administration are delegated.

The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

Verification of Provider Qualifications
Entity Responsible for Verification:
The Iowa Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Other Service

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

Service Title:

Self Directed Community Support and Employment

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's service worker. Services may include self-directed payment for social skills development, career placement, vocational planning, and independent daily living activity skill development. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated
setting in the general workforce, in a job that meets personal and career goals.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or 2) payments that are passed through to users of supported employment services.

Transportation may be covered for members from their place of residence and the employment site as a component of this service and the cost may be included in the rate.

The following are examples of supports a member can purchase to help the member live and work in the community:

o Career counseling
o Career preparation skills development
o Cleaning skills development
o Cooking skills development
o Grooming skills development
o Job hunting and career placement
o Personal and home skills development
o Safety and emergency preparedness skills development
o Self-direction and self-advocacy skills development

o Social skills development training
o Supports to attend social activities
o Supports to maintain a job
o Time and money management
o Training on use of medical equipment
o Utilization of public transportation skills development
o Work place personal assistance

Participants (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their case manager and ISB to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Community support and employment services must be identified on the individual budget plan. The individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget. Services that may be included in determining the individual budget amount for a member in the
HCBS brain injury waiver are:
1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.
7. Supported community living.
8. Supported employment.
9. Transportation

A utilization adjustment rate is applied to the individual budget amount. Please see Section E- 2- b ii for details on how the CCO budget is created. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services.
Please see Section E- 2- b ii. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Businesses

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Self Directed Community Support and Employment

Provider Category:
Individual
Provider Type:
Individual or Businesses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

All persons providing these services must be at least 18 years of age. All persons must be able to demonstrate to the member the ability to successfully communicate with the member. Individuals and businesses providing services and supports shall have all the necessary licenses required by federal, state and local laws and regulations

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, the Independent Support Broker and the Financial Management Service.

Frequency of Verification:

As necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Self Directed Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:
1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

Participants (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their case manager and ISB to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Individual directed goods and services must be documented on the individual budget. The individual budget limit will be based on the service plan and the need for the services available to be converted. A utilization adjustment rate is applied to the individual budget amount. Please see Section E- 2- b ii for details on how the CCO budget is created.

The followiong goods and services may not be purchased using a self-directed budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

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

Participant-directed as specified in Appendix E
Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Businesses

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Self Directed Goods and Services

Provider Category:
Individual
Provider Type:
Individual or Businesses
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
All persons providing these services must be at least 18 years of age. All persons must be able to demonstrate to the member the ability to perform the task or tasks hire to perform. All persons hired must have the availability to successfully communicate with the member. Individuals and businesses providing services and supports shall have all the necessary licenses required by federal state and local laws and regulations

Verification of Provider Qualifications

Entity Responsible for Verification:
The member, the independent support broker and the financial management service
Frequency of Verification:
Verified by the consumer

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Self Directed Personal Care - Consumer Choices Option

HCBS Taxonomy:

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

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

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

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Self-directed personal care services are services and/or goods that provide a range of assistance in the member's home or community that they would normally do themselves if they did not have a disability; activities of daily living and incidental activities of daily living that help the person remaining the home and in their community. This assistance may take the form of hands-on assistance (actually performing a task for a person) or cuing to prompt the participant to perform a task. Personal care may be provided on an episodic or on a continuing basis.

Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by State law. These services are only available for those that self-direct. The member will have budget authority over self-directed personal care services. The dollar amount available for this service will be based on the needs identified on the service plan. Overlapping of services is avoided by the use of a case manager who manages all services and the entry into the ISIS system. The case manager and interdisciplinary team determine which service is necessary and authorize transportation for both HCBS and self-directed services.

Participants (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their case manager and ISB to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Self-directed personal care services need to be identified on the individual budget plan. The individual budget limit will be based on the service plan and the need for the services available to be converted. A utilization adjustment rate will be applied to the individual budget amount. Transportation costs within this service is billed separately and not included in the scope of personal care. Please see Section E-2- b ii. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Self Directed Personal Care - Consumer Choices Option

Provider Category:
Individual

Provider Type:
Individual or Business

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
All persons providing these services must be at least 16 years of age. All persons must be able to demonstrate to the consumer the ability to successfully communicate with the consumer. Individuals and businesses providing services shall have all the necessary licenses required by federal, state and local laws and regulations. The consumer and the independent support broker are responsible for determining provider qualifications for the individual employees identified on the individual budget

Verification of Provider Qualifications

Entity Responsible for Verification:
The member and the Independent Support Broker and the Financial Management Service.

Frequency of Verification:
As necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Specialized Medical Equipment

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

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

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

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Specialized Medical Equipment shall include medically necessary items for personal use by the member with a brain injury which provide for the health and safety of the member which are not ordinarily covered by Medicaid, and are not funded by educational or vocational rehabilitation programs, and are not provided on a voluntary means. Items reimbursed with waiver funds are in addition to anhy medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture design and installation. This includes but is not limited to : electronic aids and organizaers, electronic mediation dispensing devices, communication devices, bath aids, and noncovered environmental control units. This includes repair and maintenace of items purchased through the waiver in addition to initial purchase cost.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Members may receive specialized medical equipment once per month until a maximum yearly usage has been reached. The yearly usage dollar amount has an upper limit and is subject to change on an annual bais.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Equipment and Supply dealers
Agency	Retail and Wholesale businesses

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment

Provider Category:
Agency

Provider Type:
Medical Equipment and Supply dealers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as a provider in the Medicaid program
Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment

Provider Category:
Agency
Provider Type:
Retail and Wholesale businesses
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled a providers in the Medicaid program
Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:

Supported Community Living

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services. definitions of the components are as follows:

Personal and home skills training services are those activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

Individual advocacy services" means the act or process of representing the individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

Community skills training services means activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:
1. Personal management skills training services are activities which assist a person 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 are the ability to maintain a household budget; plan and prepare nutritional meals; ability to use community resources such as public transportation, libraries, etc., and ability to select foods at the grocery store.
2. Socialization skills training services are those activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.
3. Communication skills training services are activities which assist a person 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 and environmental support services means 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 means activities and expenditures designed to assist the person to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from medical services. Members needing transportation to and from medical services must use the state plan medical transportation services.

Treatment services means activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.
1. Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.
2. Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person's functioning in response to the physical, emotional, and social environment.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit of service is:
(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for 8 or more hours per day as an average over a 7-day week and the member's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision. The cost per unit is capped at the average ICF/ID rate calculated retrospectively each year.
(2) 15 minute units when subparagraph (1) does not apply. 15 minute unit reimbursement amounts cannot exceed the fee schedule caps published in the Iowa Administrative Code 441 - 77.79(1).

For daily unit reimbursement, the 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. The cost of transportation may be included in the rate of the services as allowed by rule. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per member per year, and the provider must maintain records to support the expenditures.

The maximum number of units available per member is as follows:
(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.
(2) 20,440 15 minute units are available per state fiscal year except a leap year when 20,496 15 minute units are available.
h. The service shall be identified in the member's individual comprehensive plan.
i. Services shall not be simultaneously reimbursed with other residential services, HCBS BI respite, Medicaid nursing, or Medicaid or HCBS BI home health aide services.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supported Community Living

Provider Category:
Agency
Provider Type:
Provider
Provider Qualifications
License *(specify):*
Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.
Certificate *(specify):*

Other Standard *(specify):*
providers shall meet the outcome-based standards set forth in subrules IAC 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1)
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.
This service does not include transportation to Medicaid covered medical services which is provided under the state plan covered benefit called Non Emergency Medical Transportation (NEMT).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with any other transportation service and may not be duplicative of any transporation service provided under the State plan.
Transportation shall not be reimbursed simultaneously with supported community living services when the SCL rate paid to provider includes the cost of member's transportation.
There is an upper rate limit that is subject to change on a yearly basis.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	HCBS Provider Agencies
Agency	Transporation Provider
Agency	Non-Emergency Medical Transporation Provider contracted with the NEMT Broker
Agency	Regional Transit Agency
Agency	Nursing Facilities
Agency	Community Action Agency
Agency	Area Agency on Aging

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
HCBS Provider Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Accredited providers of Home and COmmuity based services
Verification of Provider Qualifications
Entity Responsible for Verification:
The Iowa Deparmtent of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Transporation Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Transportation providers that contract with county governments
Verification of Provider Qualifications
Entity Responsible for Verification:
The Iowa Department of Human Services, the Iowa medicaid Enterprise
Frequency of Verification:
Every four years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Non-Emergency Medical Transporation Provider contracted with the NEMT Broker
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The Provider must have a current contract with the NEMT broker to provide NEMT services in order to enroll to provider BI Waiver transporation under this qaulfiication.

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Medicaid Enterprise, Provider Services contractor
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Regional Transit Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Regional transit agencies as recognized by the Iowa Department of Transportation.
Verification of Provider Qualifications
Entity Responsible for Verification:
The Iowa Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Every four years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Nursing Facilities
Provider Qualifications
License *(specify):*
Nursing facilities licensed under Iowa Code chapter 135C.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Community Action Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Community action agencies as designated in Iowa Code section 216A.93.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Humans Services Iowa Medicaid Enterprise
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Area Agency on Aging
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Area agencies on aging as designated in 321—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services
Verification of Provider Qualifications
Entity Responsible for Verification:
The Iowa Department of Human Services, the Iowa Medicaid Enterprise
Frequency of Verification:
Every four years.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

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

Case Management may be provided to waiver particpants by four different provider types. The individual counties within the state establish contracts for providing targeted case management within the county. The TCM provider options include TCM provided by: Department of Human Services, County Case Management, private case management entities, or providers that are accredited for case managemet by national accrediting bodies (e.g., CARF). All TCM units are required to be accredited by the state of Iowa Mental Health and Disabilities Services for Chapter 24 case management services.

Appendix C: Participant Services

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

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

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

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

Iowa code requires that any individual or employee of an agency who provides direct services to members under Home and Community Based Services is required to have a state and national criminal background check.

Agency personal records are reviewed during provider site visits by the HCBS Quality Oversight Unit to ensure checks have been completed. The provider agency is responsible for completing the required waiver to perform the criminal background check and submitting to the Department of Public Safety who conducts the check.

Background checks are rerun anytime there is a complaint related to additional criminal charges against a provider and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis.

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

No. The State does not conduct abuse registry screening.

Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

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

Iowa code requires that any employee of an agency who provides direct services to members under the Home and Community Based Waiver programs are required to be screened for both child and adult abuse. The Department of Human Services maintains this registry. Personnel records are reviewed during provider site visits to ensure screenings have been conducted. The provider agency is responsible for completing the required abuse screening form and submitting it to the Department of Human Service to conduct the screening.

Individual providers are also being screened as explained in C-2a.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Residential Care Facility	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

It is required that all members receiving waiver services in a Residential Care Facility have a choice of where they live and have full access to community resources and activities. This is assured during the quality assurance process reviews with members to assure that seven focus areas are met for individuals in larger facilities and to maintain the home of choice for the member. The seven focus areas include: members are productive, members use community resources, members have relationships, members have input into their service plans, members maintain good health, members are safe, members have impact and choice on their services. These focus areas includes such standards that members have privacy, have their own rooms and have access to cooking facilities to provide for a homelike setting. Visitors can come at a time that the member prefers and is convenient to the member.
The department will work with CMS to develop and implement a settings transition plan to meet the new rules for HCBS settings

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Care Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Consumer Directed Attendant Care (CDAC) unskilled	
Respite	
Home and Vehicle Modification	
Prevocational Services	
Supported Employment	
Consumer Directed Attendant Care - Skilled	
Supported Community Living	
Interim Medicial Monitoring and Treatment (IMMT)	
Adult Day Care	
Personal Emergency Response System or Portable Locator System	
Self Directed Community Support and Employment	
Financial Management Service - Supports the self-direction option	
Self Directed Personal Care - Consumer Choices Option	
Transportation	
Independent Support Broker - Consumer Choices Option	
Behavioral Programming	
Self Directed Goods and Services	
Specialized Medical Equipment	
Family Counseling and Training Services	
Case Management	

Facility Capacity Limit:

For Respite, SCL and And CDAC , rules do not limit the size of the living environment as individaul's may reside in a variety of living environments

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	

Standard	Topic Addressed
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

When services are proided in a RCF, the facility must meet two sets of standards: waiver and Department of Inspection and Appeals (DIA). DIA is resposnible for the licensing of the facility. The HCBS BI standards address the service delivery standards.

Appendix C: Participant Services

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

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

No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

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

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

The State does not make payment to relatives/legal guardians for furnishing waiver services.

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

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

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

A member's relative or legal guardian may provide services to a member on the BI waiver. This applies to guardians of their adult children and not to a minor child. The relative or legal guardian may be an Individual Consumer Directed Attendant Care provider, an employee under the Consumer Choices Option program, or an employee hired by a provider agency. There are no limitations on the types of services provided, however, when the relative or legal guardian is the CDAC or CCO provider, the case manager and interdisciplinary team determine the need for and the types of activities provided by the relative or legal guardian. If the relative or legal guardian is an employee of a provider agency, it is the responsibility of the provider to assure the relative or legal guardian has the skills needed to provide the services to the member. In many situations, the Medicaid member requests the guardian provide services, as the guardian knows the member and their needs best. In other circumstances, there are no other qualified providers available when the service is needed or a lack of staff in the area to provide the service. The rate of pay and the care provided by the legally responsible person is identified and authorized in the member's plan of care that is authorized and monitored by the member's case manager.

The case manager is responsible to monitor service plans and assure the services authorized in the member's plan are received. In addition, information on paid claims of the individual member is available in ISIS for the case manager to review. The ISIS System compares the submitted claim to the services authorized in the plan of care prior to payment. The claim will not be paid if there is a discrepancy between the amount billed and the rate of pay authorized in the plan.

The state also completes post utilization audits on BI Waiver providers verifying that services rendered match the service plan and claim process. This applies to Individual CDAC providers and provider agencies.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Iowa has Medicaid providers outreach services through the Iowa Medicaid Provider Services Department that markets enrollment. Potential providers may access an application on line through the website or by calling the providers members service number. Iowa Medicaid Enterprise Provider Services Department must respond in writing within five working days once a provider enrollment application is received to either accept their enrollment application and approve the provider as a Medicaid provider or request more information. In addition, waiver quality assurance staff and waiver program managers as well as county and state case managers and service workers market qualified providers to enroll in Medicaid.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
QP-1a: Number and percent of waiver provider enrollment applications verified against the appropriate licensing and/or certification entity. Numerator = # of enrollment applications verified Denominator = # of enrollment applications.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OnBase (workflow managemt) reports are used to retrieve data associated with the number of enrollment applications that are verified and approved. Data is inductively analyzed at a 100% level.

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

Data Aggregation and Analysis:

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

Performance Measure:
QP-2a: Number and percent of licensed / certified provider enrollments indicating that abuse and criminal background checks were completed prior to direct service delivery. Numerator = # of background checks conducted on licensed/certified enrolling providers prior to service delivery Denominator = # of licensed/certified enrolling providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OnBase (workflow management) reports are used to retrieve data associated with the number of enrollment applications that are verified and approved. Data is inductively analyzed at a 100% level.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
QP-3a: Number and percent of currently enrolled licensed / certified providers verified against the appropriate licensing and/or certification entity. Numerator = # of licensed/certified providers verified at reenrollment Denominator = # of licensed/certified providers reenrolling.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OnBase (workflow management) reports are used to retrieve data associated with the number of enrollment applications that are verified and approved. Data is inductively analyzed at a 100% level.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
QP-4a: Number and percent of current licensed / certified providers who indicates that abuse and criminal background checks were completed prior to direct service delivery. Numerator = # of re-enrolling licensed/certified providers who indicate that abuse and criminal background checks were completed prior to

direct service delivery Denominator = # of licensed/certified providers reenrolling.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OnBase (workflow management) reports are used to retrieve data associated with the number of enrollment applications that are verified and approved. Data is inductively analyzed at a 100% level.

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

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
QP-1b: Number and percent of non-licensed / non-certified applicants who met the required provider standards. Numerator = # of applicants who met the required provider standards Denominator = # of applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OnBase reports are used to retrieve data associated with the number of enrollment applications with approved standards. Data is inductively analyzed at a 100% level.

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

Specify: Contract entity		**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
QP-2b: Number and percent of currently enrolled non-licensed/non-certified providers who meet the required provider standards upon reenrollment. Numerator = # of currently enrolled non-licensed/non-certified providers who met provider standards at reenrollment Denominator = # of reenrolling nonlicensed/ non-certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OnBase reports are used to retrieve data associated with the number of reenrollment applications with approved standards. Data is inductively analyzed at a 100% level.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
QP-1c: Number and percent of providers, specific by waiver, that meet training requirements as outlined in state regulations. Numerator = # of providers meeting training requirements Denominator = # of providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OnBase reports are used to retrieve data associated with the number reviewed providers who meet training requirements. Data is inductively analyzed of 100% sample spread over 5 years.

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Provider Services Unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment.

The Home and Community Based Services (HCBS) Quality Oversight Unit is responsible for reviewing provider records at a 100% level over a three
to five year cycle, depending on certification or accreditation. If it is discovered that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for
noncompliance and eventually disenrolled or terminated is noncompliance persists.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If it is discovered by Provider Services Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, they are required to correct deficiency prior to enrollment or reenrollment approval. Until they make these corrections, they are ineligible to provide services to waiver members.

If it is discovered during HCBS Quality Oversight Unit review that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated is noncompliance persists.

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

ii. **Remediation Data Aggregation**

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

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

c. Timelines

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

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

Applicable - The State imposes additional limits on the amount of waiver services.

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

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

Each member is subject to a maximum monthly dollar amount for all services received under the Brain Injury Waiver with the exception of Case Management and Home and Vehicle Modifications. This limit is subject to change on a yearly basis. In addition, members are subject to an annual limit for Home and Vehilce Modifications and Specilized Medical Equipment both of which are subject to change on a yearly basis.
Supported Employment is alos limited to 160 units per week.
The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services and may choose to employ providers of services and supports.

Individual budget amount.
A monthly individual budget amount shall be set for each member. The member's department service worker or Medicaid targeted case manager shall determine the amount of each member's individual budget, based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.
(1) Services that may be included in determining the individual budget amount for a consumer in the HCBS BI waiver are:
1. Consumer-directed attendant care (unskilled).
2. Adult Day Care
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.
(2) The department shall determine an average unit cost for each service listed in subparagraph (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.
(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.
(5) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.
(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month. The case manager or Service Worker may change the services ordered for the next month if services are insufficient to meet current need. For members having needs that exceed the upper limits allowed for under the Brain Injury waiver, an exception to policy may be requested.

Development of the individual budget.
The individual support broker shall assist the consumer in developing and implementing the consumer's individual budget. The individual budget shall include:
(1) The costs of the financial management service.
(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.
(3) The costs of any services and supports chosen by the member as described in paragraph "d."

f. Budget authority.
The member shall have authority over the individual budget authorized by the department to perform the following tasks:
(1) Contract with entities to provide services and supports as described in this subrule.
(2) Determine the amount to be paid for services with the exception of the independent support broker and the financial management service. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).
(3) Schedule the provision of services.
(4) Authorize payment for waiver goods and services identified in the individual budget.
Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.
(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority.
The consumer may delegate responsibility for the individual budget to a representative in addition to the independent support broker.
(1) The representative must be at least 18 years old.
(2) The representative shall not be a current provider of service to the member.
(3) The consumer shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.
(4) The representative shall not be paid for this service.
Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

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

1. Currently, the state has assumptions about the status of sites of service and compliance with the newly finalized regulations on the HCB setting requirements. The state feels that a large proportion of our HCBS members are served in settings that fully comport with the HCB setting requirements as the state has pushed community integration for a number of years. The state believes that the most difficult setting transitions will involve agencies providing services in RCFs and groupings of properties in close proximity. We have received commitments from our provider agencies and stakeholders to cooperate and collaborate in the HCBS settings transition process.
2. The state is working furiously to begin the assessment process for all types of service sites. The state will use the resulting information to work with individual providers on remediation to comply fully with the HCB setting requirements as outlined in 42 CFR 441.30(c)(4)-(5). Moving forward, the state will utilize existing and modified operational processes to ensure that all waiver setting meet federal HCB setting requirements on an ongoing basis.
- Provider pre-enrollment and screening processes developed, in accordance with requirements outlined in PPACA, shall incorporate HCB setting assessment when applicable.
- Newly enrolled HCBS providers will be distributed information about the importance and qualities of member integration into the community as well as the HCB setting requirements outlined in 42 CFR 441.30(c)(4)-(5). Providers will additionally be expected to certify understanding and intent to adhere to the HCB setting requirements outlined in CFR.
- All HCBS providers will be monitored for compliance with HCB setting requirements as part of continuing onsite and desk reviews performed by the HCBS Quality Oversight Unit.
- The Program Integrity Unit shall report to LTC Policy and HCBS Quality Oversight Unit any settings discovered while onsite when it is determined that they are non-compliant with the HCB setting requirement outlined in 42 CFR 441.30(c)(4)-(5).
- The Provider Cost Audit and Rate Setting Unit shall report to LTC Policy and HCBS Quality Oversight Unit any settings discovered while onsite or reviewing site cost information when it appears that sites are non-compliant with the HCB setting requirement outlined in 42 CFR 441.30(c)(4)-(5).