Department of HUMAN SERVICES

Home- and Community-Based Services
Intellectual Disability Waiver
Information Packet

The Medicaid Home- and Community-Based Services Intellectual Disability Waiver (HCBS ID) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective.

In addition to home and community-based waiver services, the Intellectual Disability Waiver enrolled members have access to Medicaid covered services and benefits. Medicaid covers a broad array of health services, in addition to the services provided by the waiver, limits out-of-pocket costs. These include, but not limited to, primary care, behavioral health services, skilled nursing care, dental, vision, and emergency care. Most of Iowa's Medicaid members are served by the managed care program called IA Health Link. Managed care organizations coordinate your care.

If you need assistance, please contact Iowa Medicaid Member Services at **1-800-338-8366** or locally in the Des Moines area at **515-256-4606**, Monday through Friday, from 8 a.m. until 5 p.m.

*For telephone accessibility assistance if you are deaf, hard-of-hearing, deaf-blind, or have difficulty speaking, call Relay Iowa TTY at **1-800-735-2942**.*

General Parameters

- Intellectual Disability (ID) waiver services are individualized to meet the needs of each member. The following services are available:
  - Adult Day Care
  - Consumer-Directed Attendant Care (CDAC)
  - Day Habilitation
  - Home and Vehicle Modifications
  - Home Health Aide
  - Interim Medical Monitoring and Treatment
  - Nursing
  - Personal Emergency Response System
  - Prevocational
  - Respite
  - Supported Community Living
  - Supported Community Living – Residential Based
  - Supported Employment
  - Transportation
  - Consumer Choices Option
- All ID waiver services must be provided in integrated community-based settings.
- The services, which are considered necessary and appropriate for the member, will be determined through an interdisciplinary team (IDT) consisting of the member, case manager or a Department of Human Services (DHS) case manager, service providers, and other persons the member chooses.
- All members will have an individualized service plan (ISP) collaboratively developed with the IDT. This plan documents the agreed upon goals, objectives, and service activities. Also collaboratively developed with the IDT, is an individual crisis plan that is designed to enable the member to prevent, self-manage, alleviate or end a crisis. The ISP for members **age 20 or less** must be developed or reviewed taking into consideration those services that may be provided through the individual education plan (IEP) and Care for Kids: Early Periodic Screening Diagnosis and Treatment (EPSDT) plan(s).
- Members shall access all other services for which they are eligible and that are appropriate to meet their needs as a precondition of eligibility for the ID waiver.
- An ISP must be developed and reviewed annually with the IDT and signed by the case manager or a Managed Care Organization (MCO) Community-Based Case Manager (CBCM).
- The member must choose HCBS services as an alternative to institutional services.
- In order to receive ID waiver services, an approved ID waiver service provider must be available to provide those services.
- Medicaid waiver services cannot be simultaneously reimbursed with another Medicaid service.
- ID waiver services cannot be provided when a member is an inpatient in a medical institution.
- Members must need and use, at a minimum, one billable unit of waiver service during each quarter of the calendar year.

- The state has designated the number of members (payment slots) that can be served under the HCBS ID program. A payment slot must be available and assigned to the individual at the time of application or after Disability Determination (DD), whichever is later.
- Funding must be available through the state of Iowa.
- The member must receive Medicaid case management services when ID waiver services begin.
- Following is the hierarchy for accessing waiver services:
  1. Private insurance
  2. Medicare
  3. Medicaid
  4. ID waiver services
- Assistance may be available through the In-Home Health-Related Care program and the Rent Subsidy program in addition to services available through the ID waiver.

Member Eligibility Criteria

Members may be eligible for HCBS ID waiver services by meeting the following criteria:

- Be an Iowa resident and a United States citizen or a person of foreign birth with legal entry into the United States.
- Have a diagnosis of an intellectual disability as determined by a psychologist or psychiatrist.
- Be determined eligible for Medicaid (Title XIX). Members may be Medicaid-eligible before accessing waiver services or be determined eligible through the application process for the waiver program. Additional opportunities to access Medicaid may be available through the waiver program even if the member has previously been determined ineligible.
- Be determined by the Iowa Medicaid Enterprise, Medical Services Unit, to need intermediate care facility for the intellectually disabled (ICF/ID) level of care.

Service Descriptions

Please note:

HCBS ID waiver services are individualized to meet the needs of each member. However, decisions regarding what services are appropriate, the number of units or the dollar amounts of the appropriate services is based on the member's needs as determined by the member and an IDT.

Adult Day Care

What: Adult day care is an organized program of supportive care in a group environment. The care is provided to members who need a degree of supervision and assistance on a regular or intermittent basis in a day care setting.

Where: In an adult day program and not the provider's home.

Unit: A unit is 15 minutes **or** a half day **or** a full day.

Career Exploration Services

What: Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially-based, informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include:

- Business tours,
- Attending industry education events,
- Benefit information,
- Financial literacy classes, and
- Attending career fairs.

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

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

Where: Prevocational career exploration services shall take place in community-based nonresidential settings.

Consumer-Directed Attendant Care (CDAC)

What: Assistance to the member with self-care tasks, which the member would typically do independently if the member was otherwise able. An individual or agency, depending on the member's needs, may provide the service. The member, parent, guardian or attorney-in-fact under a durable power of attorney for health care shall be responsible for selecting the individual or agency that will provide the components of the CDAC services to be provided.

The CDAC service may include assistance with non-skilled and skilled services. The skilled services must be done under the supervision of a professional registered nurse or licensed therapist working under the direction of a physician. The registered nurse or therapist shall retain accountability for actions that are delegated.

Skilled services may include:

- Tube feedings,
- Intravenous therapy,
- Parenteral injections,
- Catheterizations,

- Respiratory care,
- Care of decubiti and other ulcerated areas,
- Rehabilitation services,
- Colostomy care,
- Care of out of control medical conditions,
- Postsurgical nursing care,
- Monitoring medications,
- Preparing and monitoring response to therapeutic diets, and
- Recording and reporting of changes in vital signs.

Non-skilled services may include:

- Dressing,
- Hygiene,
- Grooming,
- Bathing supports,
- Wheelchair transfer,
- Ambulation and mobility,
- Toileting assistance,
- Meal preparation,
- Cooking,
- Eating and feeding,
- Housekeeping,
- Medications ordinarily self-administered,
- Minor wound care,
- Employment support,
- Cognitive assistance,
- Fostering communication, and
- Assisting with or accompanying during transportation.

Employment support includes assistance needed to go to or return from the place of employment and assistance with job-related tasks while the member is on the job site.

A determination must be made regarding what services will benefit and assist the member. Those services will be recorded in the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372. This *Agreement* becomes part of the ICP developed for the member.

This service is only appropriate if the member, parent, guardian, or attorney-in-fact under a durable power of attorney for health care has the ability to and is willing to manage all aspects of the service.

Where: In the member's home or community. Not in the provider's home.

Does not include: The following items are not included:

- Daycare
- Child care
- Respite
- Room and board
- Parenting
- Case management
- Cost of transportation

- Supervision of the member
- Assistance with understanding or performing essential job functions

CDAC cannot replace a less expensive service.

A CDAC provider may **not** be the spouse of the member, a parent or stepparent of a member aged 17 or under, or the member's legal representative.

An individual CDAC provider cannot be the recipient of respite services provided on behalf of a member receiving HCBS ID services.

The cost of nurse supervision, if needed.

Unit: A unit is 15 minutes.

Maximum units: The case manager of MCO CBCM, working with the member and the IDT, establishes a dollar amount that may be used for CDAC. The amount is then entered into the comprehensive service plan along with information about other HCBS services the member may receive. This monetary information is also entered into the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372, along with the responsibilities of the member and the provider, and the activities for which the provider will be reimbursed.

The member and the provider come to an agreement on the amount of service needed and the cost per unit. The *Agreement* must be signed and dated by the member and the provider. A completed copy of the *Agreement* is distributed to the member, the provider, and the case manager. The *Agreement* becomes part of the comprehensive service plan. These steps **must** be completed **before** service provision.

When CDAC is provided by an assisted living facility, please note the following:

- The case manager should be aware of and have knowledge of the specific services included in the assisted living facility contract to ensure the following:
  - That assisted living facility services are not duplicative of CDAC services
  - Knowledge of how the member's needs are being addressed
  - Awareness of the member's unmet needs that must be included in the care plan
- CDAC payment does not include costs of room and board.
- Each member must be determined by Iowa Medicaid Enterprise, Medical Services Unit, to meet ICF/ID level of care.
- The CDAC fee is calculated based on the needs of the member and may differ from individual to individual.

Provider enroll: The provider must be enrolled with the Department's fiscal agent and certified as a CDAC provider **before** the completion of the *HCBS Consumer-Directed Attendant Care Agreement*. Services provided before certification and completion of this *Agreement* will not be reimbursed.

It may be important for the member to enlist more than one CDAC provider. Back up services may be necessary in case of an emergency.

Billing: The member, as well as the provider, must sign the *Claim for Targeted Medical Care*

before it is submitted for payment. This verifies that the services were provided as shown on the billing form.

Day Habilitation

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

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

Day habilitation activities may include:

- Identifying the member's interests, preferences, skills, strengths and contributions,
- Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,
- Planning and coordination of the member's individualized daily and weekly day habilitation schedule,
- Developing skills and competencies necessary to pursue competitive integrated employment,
- Participating in community activities related to hobbies, leisure, personal health, and wellness,
- Participating in community activities related to cultural, civic, and religious interests,
- Participating in adult learning opportunities,
- Participating in volunteer opportunities,
- Training and education in self-advocacy and self-determination to support the member's ability to make informed choices about where to live, work, and recreate,
- Assistance with behavior management and self-regulation,
- Use of transportation and other community resources,
- Assistance with developing and maintaining natural relationships in the community,
- Assistance with identifying and using natural supports,
- Assistance with accessing financial literacy and benefits education,

- Other activities deemed necessary to assist the member with full participation in the community, developing social roles and relationships, and increasing independence and the potential for employment.

Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home.

Where: In an integrated community-based setting. Not in the member's home.

Does not include: Services shall not be provided in the member's home, except when using the family training option. For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member's home.

Services shall not include vocational or prevocational services and shall not involve paid work.

Services shall not duplicate or replace education or related services defined in the Education of the Handicapped Act.

Unit: A unit is 15 minutes **or** a full day (4 to 8 hours).

When using the family training option, a unit is 15-minutes.

The family training option is limited to a maximum of 10 hours per month.

Home and Vehicle Modification (HVM)

What: Physical modifications to the home and vehicle that directly address the member's medical health or remedial need. Covered modifications must be necessary to provide for the health, welfare, and safety of the member and to increase or maintain independence. The Iowa Medicaid Enterprise (IME) reviews all modification requests individually and a determination is made regarding the appropriateness of the modification request.

Where: In the member's home or vehicle. **Please note that only the following modifications are included**:

- Kitchen counters, sink space, and cabinets
- Special adaptations to refrigerators, stoves, and ovens
- Bathtubs, bath chairs and toilets to accommodate transfer, special handles and hoses for showerheads, water faucet controls, and accessible shower and sink areas
- Grab bars and handrails
- Turnaround space adaptations
- Ramps, lifts, and door, hall, and window widening
- Fire safety alarm equipment specific for disability
- Voice activated, sound activated, light activated, motion activated, and electronic devices directly related to the member's disability

- Vehicle lifts, driver specific adaptations, remote start systems, including such modifications already installed in a vehicle
- Keyless entry systems
- Automatic opening device for home or vehicle door
- Special door and window locks
- Specialized doorknobs and handles
- Plexiglas replacement for glass windows
- Modification of existing stairs to widen, lower, raise or enclose open stairs
- Motion detectors
- Low pile carpeting or slip resistant flooring
- Telecommunications device for people who are deaf
- Exterior hard surface pathway
- New door opening
- Pocket doors
- Installation or relocation of controls, outlets, and switches
- Air conditioning and air filtering if medically necessary
- Heightening of existing garage door opening to accommodate modified van

Does not include: The following items are not included:

- Modifications that increase the square footage of the home
- Items for replacement that are the responsibility of the homeowner or landlord
- Vehicle purchase
- Fences
- Furnaces
- Repairs or any modifications or adaptations available through regular Medicaid

Unit: A unit is the cost of the completed modification or adaptation.

Maximum: The maximum lifetime benefit is $5493.88

Home Health Aide Services (HHA)

What: Unskilled medical services that provide direct personal care. This service may include assistance with activities of daily living such as:

- Helping the recipient to bathe,
- Observation and reporting of physical or emotional needs,
- Helping the recipient to get in and out of bed,
- Reestablishing activities of daily living,
- Caring for hair and teeth,
- Exercise, and
- Take medications specifically ordered by the physician (but ordinarily self-administered).

Certain household services may be performed by the aide in order to prevent or

postpone the member's institutionalization. Domestic or housekeeping services, which are not related to member care, are not covered services if personal care is not rendered during the visit.

Instruction, supervision (for adults), support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

Home health aide as a waiver service may be accessed ***after*** accessing services under the Medicaid state plan.

Where: In the member's home. Not in the provider's home.

Does not include: Homemaker services such as cooking and cleaning or services which meet the intermittent guidelines or those provided under the EPSDT authority.

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

Medicaid intermittent coverage: Regular Medicaid provides for intermittent coverage of skilled nursing and home-health aide services provided in the person's home for both children and adults. Services are usually provided two to three hours per day for two to three days per week. Intermittent skilled nursing coverage includes visits up to five days per week and daily or multiple daily visits for wound care or insulin injections. Intermittent home-health aide coverage includes visits twice per day up to seven days per week for persons attending school or working or when ordered by the physician and included in the plan of care, not to exceed 28 hours per week.

Care for Kids program: EPSDT services for persons under age 21 only include private duty nursing and personal care services, which meet the definition of medical necessity, as provided by the Centers for Medicare and Medicaid Services (CMS) for EPSDT. Services may be provided to a child outside of the child's residence when normal life activities take the child outside the residence.

Services not covered by EPSDT include:

- Services to children with Medicaid HMO coverage
- Mental health services to children enrolled in the Iowa Plan
- Well child care
- Respite
- Transportation
- Homework assistance
- Services to other household members

Unit: A unit is one hour.

Maximum units: 14 hours per week

Interim Medical Monitoring and Treatment (IMMT)

What: Monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. Services are available to children and adults. Interim medical monitoring and treatment (IMMT) services shall provide experiences for each member's social, emotional, intellectual, and physical development. The service will include comprehensive developmental care and any special services for a member with special needs. It will include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

The service allows the member's usual caregivers to be employed. IMMT may also be used after the death of a usual caregiver. IMMT services may include supervision for the child during transportation to and from school when not available through school or other sources. IMMT services may also be provided for a limited period of time when the usual caregiver is involved in the following circumstances:

- Attendance at academic or vocational training
- Employment search
- Hospitalization
- Treatment for physical or mental illness

Where: Services may be provided in:

- The member's home,
- A registered group child care home,
- A registered family child care home,
- A licensed child care center, or
- During transportation to and from school.

Providers of this service:

- Must be at least 18 years of age.
- Cannot be the spouse of the member.
- Cannot be the parent or stepparent of a member age 17 or under.
- Cannot be the member's legal representative.
- Cannot be the usual caregiver.
- Must be qualified by training or experience as determined by the usual caregiver.

A licensed medical professional on the member's IDT must be able to provide medical intervention or intervention in a medical emergency.

Does not include: May not duplicate any regular Medicaid or waiver services provided under the state plan.

Do not use this service to replace day care for children that do not require medical monitoring and treatment.

Medicaid intermittent coverage: Regular Medicaid provides for intermittent coverage of skilled nursing and home health aide services provided in the person's home for both children and adults. Services are usually provided two to three hours per day for two to three days per week. Intermittent skilled nursing coverage includes visits up to five days per week and daily or multiple daily visits for wound care or insulin injections.

Intermittent home health aide coverage includes visits twice per day up to seven days per week for persons attending school or working or when ordered by the physician and included in the plan of care, not to exceed 28 hours per week.

Care for Kids program: EPSDT services for persons under age 21 only include private duty nursing and personal care services which meet the definition of medical necessity as provided by CMS for EPSDT. Services may be provided to a child outside of the child's residence when normal life activities take the child outside the residence.

Services not covered by EPSDT include the following:

- Services to children with Medicaid HMO coverage
- Mental health services to children
- Well child care
- Respite
- Transportation
- Homework assistance
- Services to other household members

Unit: A unit is 15 minutes.

Maximum: 48 units (12 hours) of service per day

Nursing

What: Nursing services are provided by a licensed nurse. The services are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include:

- Observation,
- Evaluation,
- Teaching,
- Training,
- Supervision,
- Therapeutic exercise,
- Bowel and bladder care,
- Administration of medication,
- Intravenous, hypodermoclysis, and enteral feedings,
- Skin care,
- Preparation of clinical progress notes,
- Coordination of services, and
- Informing the physician and other personnel of changes in the member's condition and needs.

Where: In the member's home. Not in the provider's home.

Does not include: Nursing services provided outside of the home or services that meet the intermittent guidelines or those provided under the EPSDT authority

Medicaid intermittent coverage: Regular Medicaid provides for intermittent coverage of skilled nursing and home-health aide services provided in the person's home for both children and adults. Services are usually provided two to three hours per day for two to three days per week. Intermittent skilled nursing coverage includes visits up to five days

per week and daily or multiple daily visits for wound care or insulin injections. Intermittent home-health aide coverage includes visits twice per day up to seven days per week for persons attending school or working or when ordered by the physician and included in the plan of care, not to exceed 28 hours per week.

Care for Kids program: EPSDT services for persons under age 21 only include private duty nursing and personal care services which meet the definition of medical necessity as provided by CMS for EPSDT. Services may be provided to a child outside of the child's residence when normal life activities take the child outside the residence.

Services not covered by EPSDT include:

- Services to children with Medicaid HMO coverage
- Mental health services to children enrolled in the Iowa Plan
- Well child care
- Respite
- Transportation
- Homework assistance
- Services to other household members

This nursing service shall not be simultaneously reimbursed with other Medicaid services. Exception: Payment may be made for supervisory visits when a registered nurse, acting in a supervisory capacity, provides supervisory visits of services provided by a home-health aide under a home-health agency plan of treatment.

Unit: A unit is one hour.

Maximum: Ten hours per week

Personal Emergency Response System (PERS)

What: An electronic device connected to a 24-hour staffed system which allows the member to access assistance in the event of an emergency. PERS also includes a portable locator system that transmits a signal to a monitoring device. The locator 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.

Where: The PERS is connected to the member's home phone and includes a portable emergency button carried by the member.

Unit: A unit is a:

- One-time purchase of equipment, **and/or**
- One time installation fee, **and/or**
- One month of service.

Maximum: 12 months of service per state fiscal year (July 1 – June 30)

Prevocational Services

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

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

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially-based informed choice regarding the goal of individual employment.

Where: In community-based nonresidential settings.

Does not include: Assisting a member in learning tasks or skills for a specific job.

Prevocational services payment shall not be made for the following:

- Services that are available to the individual under a program funded under Section 10 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et. seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.
- Services available to the individual that duplication or replace education or related services defined in the Individuals with Disabilities Education Act.
- Compensation to members for participating in prevocational services.
- Support for members volunteering in for-profit organization and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g. hospitals, nursing homes), and support for members volunteering to benefit the service provider.
- The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services where services are aimed at teaching skills for specific types of jobs rather than general skills.

- A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

Respite

What: Respite care services are services provided to the member that gives temporary relief to the usual caregiver and provides 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.

- **Specialized respite** means respite provided on a staff-to-member ratio of one-to-one or higher for members with specialized medical needs requiring monitoring or supervision provided by a licensed registered nurse or licensed practical nurse.
- **Group respite** means respite provided on a staff-to-member ratio of less than one-to-one.
- **Basic individual respite** means respite provided on a staff-to-member ratio of one-to-one or higher for members without specialized medical needs that would require care by a licensed registered nurse or licensed practical nurse.

Where: Respite may be provided in:

- The member's home,
- Another family's home,
- Camps,
- Organized community programs (YMCA, recreation centers, senior citizens' centers, etc.),
- ICF/ID,
- RCF/ID,
- Hospital,
- Nursing facility,
- Skilled nursing facility,
- Assisted living program,
- Adult day care center,
- Foster group care,
- Foster family home, or
- DHS licensed daycare.

Respite provided outside the member's home or outside a facility in locations covered by the facility's licensure, certification, accreditation, or contract must be approved by the parent, guardian, or usual caregiver and IDT, and must be consistent with the way the location is used by the general public. Respite in these locations may not exceed 72 continuous hours.

Does not include: Services shall not be reimbursable if the living unit is otherwise reserved for persons on a temporary leave of absence.

Respite ***cannot*** be provided to members residing in the family, guardian, or usual caregiver's home during the hours in which the usual caregiver is employed unless the member is attending a 24-hour residential camp program.

Respite shall not be simultaneously reimbursed or provided with duplicative services under the waiver.

Unit: A unit is 15 minutes.

Maximum units: 14 consecutive days of 24-hour respite care may be reimbursed.

Supported Community Living (SCL)

What: SCL provides up to 24 hours of support per day based on the member's needs.

This service is designed to assist the member with daily living needs. Assistance may include, but is not limited to:

- Personal and home skills,
- Community skills,
- Personal needs,
- Transportation,
- Treatment services.

For members who are age 20 or under and who require more than 208 units of SCL per month, the comprehensive service plan must be developed taking into consideration the services that will be provided through the Care for Kids program. The case manager must document justification of the member's need in the service file for children requiring more than 208 units of SCL. The duration of services shall be based on age appropriateness and individual attention span.

Where: Members can receive SCL in the family home, the guardian's home or integrated community settings.

All living arrangements must be integrated into the community.

The typical and preferred living unit may include one to four persons. Special certification may be available that allows five-person living arrangements.

Does not include: The following items are not included:

- Room and board costs
- Academics
- Medical services
- Vocational services
- Daycare
- Case management
- Babysitting
- Parenting

Unit: A unit is 15 minutes **or** one day.

A daily unit applies to members who live outside of their family, legal representative or foster family home and for whom a provider has primary responsibility for supervision or structure during the month. A daily unit applies to members who receive on-site staff

supervision for 8 or more hours per day as an average over one month.

Supported Community Living – Residential Based

What: Residential-based supported community living provides 24-hour daily support to children aged 17 and under living outside of their family home. Services must also address the ordinary daily living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

A separate slot must be requested under this category before members can be determined eligible for the HCBS residential-based supported community living under the ID waiver.

Allowable service components include the following:

- Daily living skills development,
- Social skills development,
- Family support development, and
- Counseling and behavior intervention services.

Where: Members must reside outside the family home in a licensed residential-based supported community living environment. The residential-based living service provider monitors the home and may assist the member and their family in locating furniture and necessary household items.

Does not include: The following items are not included:

- Room and board costs
- Vocational needs
- Academics
- Daycare
- Medicaid case management
- Other case management
- Any other services that the child can otherwise obtain through Medicaid

Unit: A unit is one day.

Supported Employment (SE)

What: Individualized services provide supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job:

- In competitive or customized employment or self-employment,
- In an integrated work setting in the general workforce, and
- At or above the state's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

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

The three components of this service are:

- **Individual supported employment**. These are services provided to obtain competitive employment. Any of the following activities may be included:
  - Benefits education
  - Career exploration
  - Employment assessment
  - Assistive technology assessment
  - Trial work experience
  - Person-centered employment planning
  - Development of visual and traditional résumés
  - Job-seeking skills training and support
  - Outreach to prospective employers on behalf of the member
  - Job analysis
  - Identifying and arranging transportation
  - Career advancement services
  - Reemployment services (if necessary)
  - Financial literacy and asset development
  - Other employment support services deemed necessary
  - Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization
  - Engagement of natural supports during initial period of employment
  - Assistive technology solutions during initial period of employment
  - Transportation of the member during service hours
  - Initial on-the-job training to stabilization
- **Long term job coaching**. These are services provided to maintain competitive employment. Any of the following activities may be included:
  - Job analysis
  - Job training and systematic instruction
  - Training and support for use of assistive technology and adaptive aids.
  - Engagement of natural supports.
  - Transportation coordination.
  - Job retention training and support.
  - Benefits education and ongoing support.
  - Supports for career advancement.
  - Financial literacy and asset development.

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

  Tier 1 1 contact per month
  Tier 2 2 – 8 hours per month
  Tier 3 9 – 16 hours per month
  Tier 4 17 – 25 hours per month
  Tier 5 26 or more hours per month

♦ **Small group employment**. A team of no more than eight individuals with disabilities in a teamwork setting receiving supports to maintain employment.

- Employment assessment.
- Person-centered employment planning.
- Job placement (limited to service necessary to facilitate hire into individual employment, paid at minimum wage or higher, for a member in small group-supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
- Job analysis.
- On-the-job training and systematic instruction.
- Job coaching.
- Transportation planning and training.
- Benefits education.
- Career exploration services leading to career advancement outcomes.
- Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.
- Transportation of the member during service hours.

  Tier 1 Groups of 2 to 4
  Tier 2 Groups of 5 or 6
  Tier 3 Groups of 7 or 8

Where: Job placements shall be made in integrated settings with the majority of co-workers being persons without disabilities. Not to be provided in the provider's home or office.

For whom: Members age 16 or older.

Does not Not included are:

include:

- Members who are eligible for similar services from the Division of Vocational Rehabilitation Services
- Members who are eligible for similar services from educational services
- Services involved in placing or maintaining members in day activity, work activity or sheltered workshop programs
- Supports for volunteer work or unpaid internships
- Tuition for educational or vocational training

Transportation

What: Transportation services for members to conduct business errands, essential shopping, to receive medical services, to travel to and from work or day programs, and to reduce social isolation.

Where: In the community as identified in the comprehensive service plan.

Does not include: Transportation simultaneously reimbursed with transportation costs that may be included in an SCL rate or medical transportation that is reimbursable through medical transportation funding

Unit: Per trip or per mile.

Consumer Choices Option

What: The **Consumer Choices Option (CCO)** 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 to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan.

CCO is a self-directed program that offers more choice, control, and flexibility over your services, as well as, more responsibility. Additional assistance is available if you choose this option. You will choose an Independent Support Broker who will help you develop your individual budget and help you recruit employees.

You will also work with a financial management service that will manage your budget for you and pay your workers on your behalf. Contact your Community-Based Case Manager, or DHS Case Manager for more information. Additional information may also be found at the website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/consumer-choices-option.

Services that may be authorized in a service plan for use in an individual budget under CCO are:

- Consumer-directed attendant care (unskilled)
- Day habilitation
- Home and vehicle modification

- Prevocational services
- Basic individual respite care
- Specialized medical equipment
- Supported community living
- Supported employment
- Transportation

Goods and services provided through CCO cannot otherwise be provided through Medicaid state plan services. Goods and services would:

- Decrease the need for other Medicaid services,
- Promote inclusion in the community, or
- Increase safety in the member's home and community.

Where: In the member's home or integrated community setting. Not in the provider's home.

Does not include: CCO cannot be used to pay for:

- Room and board,
- Sheltered workshop services,
- Childcare,
- Personal entertainment items,
- Experimental and non-FDA-approved medications and therapies
- Home furnishings
- Insurance premiums or copayments
- Motorized vehicles
- Nutritional supplements,
- Recreational purchases not related to an assessed need,
- Repairs of motor vehicles,
- School tuition, or
- Service animals.

CCO funds may not be used to pay for services otherwise provided through Medicaid.

Unit: A monthly budget amount is established for each member based on the type and amount of authorized services in a member's service plan that are selected to convert to the CCO budget.

Application Process

The application process for the ID waiver requires a coordinated effort between DHS and non-department agencies on behalf of the prospective member. If you are currently working with DHS personnel, please contact that person regarding the application process.

Please respond immediately to correspondence from an income maintenance worker, a Community-Based Case Manager or a Medicaid case manager. This will decrease the amount of time needed to complete the application process and assist in communication.

1. Application for Medicaid (Title XIX) and the ID waiver is made with an income maintenance (IM) worker at the local DHS office. The IM worker will secure a payment slot or put the member's name on a waiting list. Upon availability of a payment slot, the IM worker will process the application and refer the member to a DHS case manager or a Medicaid case manager.

For adults applying for the ID waiver, an appointment will be scheduled with the IM worker. For children applying for this waiver, telephone contact will be made to the family home. Documentation necessary to complete this contact may include:

- Financial records
- Title XIX card
- Letter of Medicaid eligibility
- Verification of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) or State Supplemental Assistance (SSA) eligibility, if applicable. If assistance is not currently being received, a request may be made to apply at the local Social Security office.

Please note: Applicants for the residential-based supported community living service for children must be preapproved by DHS before service provision.

2. The Supports Intensity Scale (SIS) assessment tool is completed by the Medicaid Core Standardized Assessment contractor or the Managed Care Organization (MCO).

3. The Iowa Medicaid Medical Services unit, will review the assessment tool to determine if member needs require ICF/ID level of care.

   If the member does not meet level of care, the IM worker will send a *Notice of Decision (NOD)* notifying the member of the denial. The member has the right to appeal the decision. The appeal process is explained on the *NOD*.

4. An interdisciplinary team meeting is conducted to determine the services that are needed, the amount of service to be provided, and the providers of the services. The interdisciplinary team meeting will be attended by the member, member's family, the case manager ID waiver service providers, and may also include other professional or support persons. The end result of the interdisciplinary team decisions will be a comprehensive service plan developed, signed, and dated by the case manager or community based case manager.

5. The Individualized Services Information System (IoWANS) process must be completed with the culmination of an approved comprehensive service plan before the implementation of services. An approved comprehensive service plan recorded in the IoWANS system authorizes payment for ID waiver services.

6. For MCO enrolled members, the MCO must approve the comprehensive service plan and authorize services.

7. The Community-Based Case Manager or the Medicaid case manager will issue a *NOD* if the member is approved to receive ID waiver services.

Estate Recovery

Estate recovery legal reference: 441 IAC 75.28(7)

Estate recovery applies to all persons who have received Medicaid on or after July 1, 1994, and are age 55 or older, or who live in a medical facility and cannot reasonably be expected to return home. This includes members on waiver programs such as the Elderly Waiver Program and Medically Needy Program.

When a Medicaid member dies, assets from their estate are used to reimburse the state for costs paid for medical assistance. This includes the full amount of capitation payments made to a Managed Care Organization (MCO) for medical and dental coverage, regardless of service use or how much the managed care entity paid for services.

Additional information may also be found at the website:
https://dhs.iowa.gov/ime/members/members-rights-and-responsibilities/estate-recovery

or contact:

Medicaid Member Services Toll Free: 800-338-8366
515-256-4606 (Des Moines area)
or
Iowa Estate Recovery Program Toll Free: 1-877-463-7887
8:00 a.m. – 5:00 p.m., Monday – Friday

Discrimination is Against the Law

The Iowa Department of Human Services (DHS) complies with applicable federal civil rights laws to provide equal treatment in employment and provision of services to applicants, employees, and clients and does not discriminate on the basis of race, color, national origin, age, disability or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

DHS:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Iowa Medicaid Member Services at 1-800-338-8366.

If you believe that DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: DHS, Office of Human Resources, by emailing contactdhs@dhs.state.ia.us or in writing to:

DHS Office of Human Resources
Hoover State Office Building, 1st floor
1305 East Walnut Street
Des Moines, IA 50319-0114

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the DHS Office of Human Resources is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al ***1-800-338-8366 (TTY: 1-800-735-2942).***

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-338-8366 (TTY: 1-800-735-2942).**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-338-8366 (TTY: 1-800-735-2942).**

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-800-338-8366** (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: **1-800-735-2942**).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-338-8366 (TTY: 1-800-735-2942).**

مقر) ***1-800-338-8366*** مقرب لصتا. ناجملاب كل رفاوتت ةيوغللا ةدعاسملا تامدخ نإف ،ةغللا ركذا تنك ثدحتت اذإ: ةظوحلم). ***1-800-735-2942***:مصلا مكبلاو فتاه

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-338-8366 (TTY: 1-800-735-2942).**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-338-8366 (TTY: 1-800-735-2942)** 전화해 주십시오.

ध्यान द : य द आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह।
1-800-338-8366 (TTY: 1-800-735-2942) पर कॉल कर ।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-338-8366 (ATS: 1-800-735-2942).**

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call **1-800-338-8366 (TTY: 1-800-735-2942).**

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-338-8366 (TTY: 1-800-735-2942).**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-338-8366 (TTY: 1-800-735-2942).**

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ့် ကျိာ်အတ်မၤစၢၤလ၊ တလၫ်ဘူဉ်လၫ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး **1-800-338-8366 (TTY: 1-800-735-2942).**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-338-8366** (телетайп: **1-800-735-2942**).