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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Iowa** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. **Program Title:**
Home and Community Based Services - Health and Disability (HD) Waiver (Managed Care Amendment)

C. **Waiver Number:IA.4111**
Original Base Waiver Number: IA.4111.

D. **Amendment Number:IA.4111.R06.02**

E. **Proposed Effective Date:** *(mm/dd/yy)*
01/01/16
Approved Effective Date of Waiver being Amended: 11/01/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
This §1915(c) amendment is being submitted concurrently with a §1915(b) waiver application to implement the Iowa High Quality Healthcare Initiative (the "Initiative"). Specific authorities requested will allow the State to require the majority of Medicaid beneficiaries to receive their nursing facility, hospice, home and community based services (HCBS) and physical and behavioral health services through managed care organizations (MCOs) selected by the State through a competitive procurement process.

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	
☑ Appendix A – Waiver Administration and Operation	
☑ Appendix B – Participant Access and Eligibility	
☑ Appendix C – Participant Services	

Component of the Approved Waiver	Subsection(s)
☑ Appendix D – Participant Centered Service Planning and Delivery	
☑ Appendix E – Participant Direction of Services	
☑ Appendix F – Participant Rights	
☑ Appendix G – Participant Safeguards	
☑ Appendix H	
☑ Appendix I – Financial Accountability	
☑ Appendix J – Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:
Implement managed care delivery system.

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Home and Community Based Services - Health and Disability (HD) Waiver (Managed Care Amendment)

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IA.4111
Waiver Number:IA.4111.R06.02
Draft ID: IA.002.06.02

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

E. Proposed Effective Date of Waiver being Amended: 11/01/12
Approved Effective Date of Waiver being Amended: 11/01/12

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

☑ **Waiver(s) authorized under §1915(b) of the Act.**

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

Iowa High Quality Healthcare Initiative-Submitted

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

☑ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☑ **§1915(b)(3) (employ cost savings to furnish additional services)**

☑ **§1915(b)(4) (selective contracting/limit number of providers)**

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

This §1915(c) amendment is being submitted concurrently with a §1915(b) waiver application to implement the Iowa High Quality Healthcare Initiative (the "Initiative"). Specific authorities requested will allow the State to require the majority of Medicaid beneficiaries to receive their nursing facility, hospice, home and community based services (HCBS) and physical and behavioral health services through managed care organizations (MCOs) selected by the State through a competitive procurement process.

The State will contract with a minimum of two, and not more than four, MCOs thereby ensuring members have the choice between entities. Further, members will receive choice counseling from an Enrollment Broker to assist in plan selection. Once a member is enrolled with an MCO he or she will have access to the State's Fair Hearing process, after exhausting the MCO's appeals system. Members can continue services while an appeal decision is pending, when the conditions of 42 CFR 438.420 are met. Additionally, the State will have an Independent Advocate or Ombudsman services available to members to assist with understanding rights, responsibilities and handling of disputes and grievances. MCOs will be responsible for critical incident reporting and management in accordance with State requirements, as well as convening a Stakeholder Advisory Board to engage consumers, their representatives, and providers. The State will ensure compliance with all managed care regulations set forth in 42 CFR §438, unless otherwise waived, and that capitation rates are developed and certified as actuarially sound, pursuant to 42 CFR §438.6.

Certain waiver participants, as described in the §1915(b) waiver will not be eligible for managed care and will therefore continue to receive services through a fee-for-service delivery system. Participants ineligible for managed care will receive services through those processes currently in place for HCBS services, whereby the State is responsible for service plan development, care management, provider network management, utilization management, reimbursement of providers, quality oversight, etc.

Given the two distinct delivery systems under which this waiver will operate, this waiver narrative will refer to beneficiaries as: (1) "members," in the case of those being served by a managed care organization; or (2) "fee-for-service participants," in the case of those being served by the State. In those instances where the State provides a service or function on behalf of all beneficiaries regardless of delivery system, the waiver narrative will refer to "participants," generally. Further, MCOs will be required to adhere to all state policies, procedures, and regulations regarding waiver services including, but not limited to, responses provided in this waiver application.

Waiver Program Summary

The goal of the Iowa HCBS Health and Disability (HD) waiver is to provide community alternatives to institutional services. Through need-based funding of individualized supports, eligible participants may maintain their position within their homes and communities rather than default placement within an institutional setting. The Iowa Department of Human Services (DHS) Iowa Medicaid Enterprise (IME) is the single state agency responsible for the oversight of Medicaid.

Individuals access waiver services by applying to their local DHS office or through the online DHS benefits portal. Each individual applying for waiver services must meet nursing facility (as defined in 42 CFR §440.40 and 42 CFR §440.155) or intermediate care facility for individuals with intellectual disabilities (ICF/ID) (as defined in 42 CFR §440.150) level of care. IME's Medical Services Unit (MSU) is responsible for determining the initial level of care assessments for all applicants, and level of care revaluations for fee-for-service participants. MCOs are responsible for conducting level of care reevaluations for their members, with IME having final review and approval authority for all reassessments that indicate a change in the level of care. Further, the MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. In the event there is a waiting list for waiver services at the time of initial assessment, applicants are advised of the waiting list and that they may choose to receive facility-based services.

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

Services include adult day care, consumer directed attendant care, counseling services, home and vehicle modification, home-delivered meals, home health aide, homemaker, interim medical monitoring and treatment, nursing, nutritional counseling,

personal emergency response system, and respite. Financial management services and independent support brokerage services, self-directed personal care, individual directed goods and services and self-directed community and employment supports will be available for the individuals who chose to self-direct their services.

Through increased legislative focus of appropriations, mental health and disability services redesign, and infrastructure development through Iowa's Balancing Incentives Payment Program, it is the goal of Iowa to offer a more uniform and equitable system of community support delivery to individuals qualifying for waiver services.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have

been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

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

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

(Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
Given character limitations within the CMS Waiver Management System, a summary of the State's public comment process and any waiver edits has been included in the Main Module, 8.B, "Additional Needed Information (Optional)." This information is also available online at http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization. In addition, DHS seeks continuous and ongoing public input through a variety of committees and organizations. Specifically, the Iowa Developmental Disability Council meets bi-monthly and provides input as necessary. DHS has appointed one staff person from the IME Long Term Care Unit to the Council, which includes various stakeholders including participants and families, providers, case managers, and other State departments. IME is also invited to attend a number of association and advocacy group meetings (i.e., Iowa Association of Community Providers, Iowa State Association of Counties, Iowa Health Care Association, and Olmstead Task Force) to provide and seek feedback on service planning, cost reporting, quality assurance documentation requirements, and case management issues. Further, the public has the opportunity to comment on Iowa Administrative rules and rule changes through the public comment process, the Legislative Rules Committee, and the DHS Council.

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

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

7. Contact Person(s)

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

Last Name:

Oudekerk

First Name:

Sally

Title:

Policy Program Manager

Agency:

Iowa Medicaid Enterprise/Iowa Department of Human Services

Address: 100 Army Post Road

Address 2:

City: Des Moines

State: **Iowa**

Zip: 50315

Phone: (515) 256-4643 **Ext:** ☐ **TTY**

Fax: (515) 256-1306

E-mail: soudeke@dhs.state.ia.us

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Iowa**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Mikki Stier

State Medicaid Director or Designee

Submission Date: Sep 24, 2015

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

Last Name: Stier

First Name: Mikki

Title: Medicaid Director

Agency: Iowa Medicaid Enterprise/Iowa Department of Human Services

Address: 100 Army Post Road

Address 2:

City: Des Moines

State: **Iowa**

Zip: 50315

Phone: (515) 256-4621 **Ext:** ☐ **TTY**

Fax: (515) 725-1360

E-mail: mstier@dhs.state.ia.us

Attachments

Attachment #1: Transition Plan

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

- ☑ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**

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

Specify the transition plan for the waiver:

Statewide MCO enrollment in the Initiative will be effective January 1, 2016. As such, the State will begin accepting MCO selections from current Medicaid enrollees beginning in fall 2015. To facilitate the MCO selection process, enrollees will receive enrollment notices that include a tentative MCO assignment based on an algorithm designed to: (1) deal the population evenly among the MCOs; and (2) assign all members of a particular family to the same MCO. As all MCOs are required to extend contract offers to all current Iowa Medicaid enrolled providers, existing provider-beneficiary relationships should be available as the program is implemented. The notice will also include information regarding all available MCO options and will provide the opportunity for enrollees to make an alternative selection prior to the tentative assignment becoming effective. The Enrollment Broker will take MCO selections and provide choice counseling to assist enrollees. Enrollees will be fully enrolled based on their tentative assignment in the absence of an alternative choice made by the required response date listed in the notice. Once fully enrolled, members will have the opportunity to change MCOs in the first 90 days of enrollment without cause. The timeline for sending these notices will be staggered based on Medicaid eligibility groups. To permit additional time and assistance for members receiving long-term services and supports, these notices will first be sent to individuals in an institution, individuals enrolled in a §1915(c) waiver, and individuals receiving §1915i home and community based services under the Iowa Medicaid State Plan.
Those participants who have not made an MCO selection, or who are otherwise ineligible for managed care enrollment as defined in the Iowa High Quality Healthcare Initiative §1915(b) waiver, will continue to receive services through fee-for-service delivery system.

Within five (5) business days of receipt of member enrollment information, MCOs will distribute enrollment materials to each member. All information will be provided to members with limited English proficiency through the provision of language services at no cost to the individual. All written materials will be provided in English and Spanish, and any additional prevalent languages identified by the State, and will be made available in alternative formats that take into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency (e.g., 508 compliance, Braille, large font, audiotape and verbal explanations of written materials). All members and potential members will be informed that information is available in alternative formats and how to access those formats.

Enrollment materials will include, but not be limited to, provider directory information and/or information on how to find a network provider near the member's residence, the MCO's contact information, the amount, duration, and scope of covered services, information regarding the availability of Member Helpline and 24-hour Nurse Call Line, procedures for obtaining benefits, a description of any restrictions on the member's freedom of choice among network providers, and information on the grievance and appeal process. Specific information regarding waiver services will include a description of the community-based case management's or integrated health home's role and responsibilities, information on how to change community based case management or integrated health homes, and when applicable, information on the option to self-direct.

For those participants transitioning from fee-for-service to managed care, MCOs will implement a comprehensive strategy, subject to State approval, to ensure a seamless transition of services during program implementation. Strategies will include timelines within which all members receiving 1915(c) waiver services will receive an in-person visit from appropriate MCO staff and an updated needs assessment and service plan. Services will not be reduced, modified or terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination.

MCOs will also ensure that members are permitted to see all current providers on their approved service plan upon initial enrollment, even on a non-network basis, until a service plan is completed and agreed upon by the member or resolved through the appeals or fair hearing process, and implemented. MCOs will extend the authorization of waiver services from a non-network provider as necessary to ensure continuity of care pending the provider's contracting with the MCO, or the member's transition to an in-network provider. MCOs will be responsible for facilitating a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the MCO without any disruption in services. Further, MCOs are contractually required to extend DHS enrolled 1915(c) HCBS waiver providers an opportunity to be part of its provider

network.

MCOs will implement plans, subject to State approval, to provide seamless, effective transition from the member's former targeted case manager, case manager, or service worker (as applicable), and any change in community-based case management. MCOs will allow members to retain their current case manager during the first six months of transition. All transition plans will be fully implemented within one year.

DHS will provide data sharing with MCOs to assist in continuity of care, including providing prior authorizations in place at the time of member transition, claims history and service plans. Further, DHS will implement oversight strategies to ensure MCO compliance with continuity of care requirements, including, but not limited to, readiness review and regular reporting.

DHS and the MCOs will also implement strategies to assist providers in the transition. DHS strategies will include educational sessions and the provision of written materials such as frequently asked questions and provider bulletins. MCOs are contractually required to implement provider communication strategies which will assist in provider transition such as publication of a provider manual, maintenance of a provider website, operation of a provider services helpline, and extensive provider training.

DHS and the MCOs will also implement a comprehensive member and stakeholder education and engagement strategy to assist in transition, ensure understanding of the program and promote a collaborative effort to enhance the delivery of high quality services to members. DHS operates an Managed Long Term Services and Supports (MLTSS) Advisory Group for long-term services and supports recipients and stakeholders. Further, the MCOs are contractually required to operate a Stakeholder Advisory Board which is charged with providing input on issues such as: (i) service delivery; (ii) quality of care; (iii) member rights and responsibilities; (iv) resolution of grievances and appeals; (v) operational issues; (vi) program monitoring and evaluation; (vii) member and provider education; and (viii) priority issues identified by members.

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

Iowa assures that the settings transition plan included with this waiver amendment or renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Iowa will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Section 1: Assessment
Iowa proposes a multifaceted approach to assessment. This will include the completion of a Settings Analysis, which will be a high-level assessment of settings within the state to identify general categories (not specific providers or locations) that are likely to be in compliance; not in compliance; presumed to be non-HCBS; or those that are not yet, but could become compliant. Other avenues for assessment will include identifying HCBS settings during provider enrollment and re-enrollment; evaluating settings through the existing HCBS quality assurance onsite review process and the provider self-assessment process; and monitoring of Iowa Participant Experience Survey (IPES) results for member experiences. Assessment activities will be incorporated into current quality assurance processes to the extent possible.

All MCOs contracting with the State to provide HCBS are required to ensure non-institutional LTSS are provided in settings which comport with the CMS HCBS requirements defined at 42 CFR 441.301(c)(4) and 42 CFR 441.710(a). MCOs will be required to ensure compliance through the credentialing and monitoring of providers and service authorization for waiver

participants.

10/1/2014- 10/31/2014: Settings Analysis - State identified HCBS settings as they potentially conform to HCBS characteristics and ability to comply in the future. General settings are classified into categories (Yes - settings fully compliant, Not Yet - settings that will comply with changes, Not Yet - setting is presumed non-HCBS but evidence may be presented for heighted scrutiny review, and No - setting do not comply) The Iowa HCBS Settings Analysis is being submitted as one component of the transition plan .
12/1/2014 - 12/31/2014: Provider Enrollment Processes - State will operationalize mechanisms to incorporate assessment of settings into existing processes for provider pre-enrollment screening by the Iowa Medicaid Enterprise (IME), provider credentialing by the managed care behavioral health organization (BHO), and HCBS provider certification by the HCBS Quality Oversight unit.
5/1/2015 - 12/31/2015: Geographic Information System (GIS) Evaluation of HCBS Provider Locations and HCBS Member Addresses - State will use GIS to analyze locations of provider sites and member addresses to identify potential areas with high concentration of HCBS.
12/1/2014 - ongoing: Onsite assessment - The State will incorporate review of settings into the review tools used by the HCBS Quality Oversight Unit for on-site reviews. Settings will be assessed during recertification reviews, periodic reviews, focused reviews, and targeted reviews. State will identify providers with sites of service that have the characteristics of HCBS or the qualities of an institution.
10/1/2014 - ongoing: Enrolled HCBS providers self-assessment - The state will modify the Provider Quality Management Self-Assessment to identify HCBS sites and to gather additional information from providers to assess sites of service that have characteristics of HCBS or the qualities of an institution. The annual self-assessment will be released to providers annually on October 1 and due to IME annually on December 1, with results compiled by February 28. The State will release the “Iowa Exploratory Questions for Assessment of HCBS Settings” document to assist providers in identifying the expected characteristics of HCBS.
8/1/2014 - ongoing: Other projects collecting HCBS setting data - State provider association will provide information and input from residential providers to the state.
12/1/2014 - ongoing: Iowa Participant Experience Survey (IPES) - State will continue to monitor IPES results to flag member experience that is not consistent with assuring control over choices and community access.
5/1/2015 - By 3/17/2019: Onsite Assessment Results Report - State compiles and analyzes findings of onsite assessments annually by July 31, with the final report completed by 3/17/19. Findings will be presented to Iowa DHS leadership and stakeholders.

Section 2: Remediation Strategies
Iowa proposes a remediation process that will capitalize on existing HCBS quality assurance processes including provider identification of remediation strategies for each identified issue, and ongoing review of remediation status and compliance. The state may also prescribe certain requirements to become compliant. Iowa will also provide guidance and technical assistance to providers to assist in the assessment and remediation process. Providers that fail to remediate noncompliant settings timely may be subject to sanctions ranging from probation to disenrollment.

6/1/2014 - 7/31/2016: Informational Letters - State will draft and finalize informational letters describing proposed transition, appropriate HCBS settings, deadlines for compliance, and technical assistance availability. BHO and MCOs will provide the same information to provider network.
12/1/2014 - 7/31/2015: Iowa Administrative Code - State will revise administrative rules chapters 441-77, 78, 79, and 83, to reflect federal regulations on HCBS settings. Rules will define HCBS setting thresholds and will prohibit new sites from being accepted or enrolled that have an institutional or isolating quality while presenting deadlines for enrolled providers to come into compliance. Rules will clarify expectations of member control of their environment and access to community. BHO will develop the same standards for provider network.
8/1/2015 - 12/31/2015: Provider Manual Revisions - State will revise HCBS provider manual Chapter 16K to incorporate regulatory requirements for HCBS and qualities of an HCBS setting. BHO will incorporate the same information into relevant provider network manuals.
12/1/2014 - ongoing: Incorporate Education and HCBS Compliance Understanding into Provider Enrollment - IME Provider Services Unit Pre-Enrollment Screening process will make adjustments to ensure that HCBS settings are evaluated when appropriate. When agencies enroll to provide HCBS services, they will be provided information on HCBS setting requirements and be required to certify that they have received, understand, and comply with these setting requirements.
12/1/2014 - ongoing: Provider Assessment Findings - State will present each provider with the results of the assessment of their organizational HCBS settings as findings occur throughout the assessment process.
12/1/2014 - 3/16/2019: Provider Individual Remediation - HCBS providers will submit a corrective action plan (CAP) for any settings that require remediation. The CAP will provide detail about the steps to be taken to remediate issues and the expected timelines for compliance. The state will accept the CAP or may ask for changes to the CAP. The state may preset remediation requirements for each organization's HCBS settings. Providers will be required to submit periodic status updates on

remediation progress. State review of CAPs will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question. The state will allow reasonable timeframes for large infrastructure changes with the condition that the providers receive department approval and provide timely progress reports on a regular basis. Locations presumed to be non-HCBS but which are found to have the qualities of HCBS will be submitted to CMS for heightened scrutiny review.
12/1/2014 - 3/16/2019: Data Collection - State and BHO and MCO will collect data from reviews, technical assistance, updates, etc. to track status of remediation efforts. Data will be reported on a regular basis or ad hoc to DHS management and CMS.
12/1/2014 - 3/1/2019: Onsite Compliance Reviews - State will conduct onsite reviews to establish levels of compliance reached by providers with non-HCBS settings following completion of their remediation schedule.
12/1/2014 - 3/16/2019: Provider Sanctions and Disenrollments - State will disenroll and/or sanction providers that have failed to meet remediation standards. State will disenroll and/or sanction providers that have failed to cooperate with the HCBS Settings Transition.
12/1/2014 - 3/16/2019: Member Transitions to Compliant Settings - If relocation of members is necessary, the state will work with case managers, service workers, and care coordinators to ensure that members are transitioned to settings meeting HCBS Setting requirements. Members will be given timely notice and due process, and will have a choice of alternative settings through a person centered planning process. Transition of members will be comprehensively tracked to ensure successful placement and continuity of service.

Section 3: Public Comment
Iowa proposes to collect public comments on the transition plan through a dedicated email address for submission of written comments, and through taking public comments directly by mail. Iowa has also previously held a comment period in November 2014 which included solicitation of comments through stakeholder forums. In addition to posting the transition plan and related materials on the Iowa Medicaid website, numerous stakeholders were contacted directly and provided with transition plan documents and information on the stakeholder forums. Stakeholders contacted include Disability Rights Iowa, the Iowa Association of Community Providers, the Iowa Health Care Association/Iowa Center for Assisted Living, Leading Age Iowa, the Iowa Brain Injury Association, the Olmstead Consumer Task Force, the Iowa Mental Health and Disability Services Commission, the Iowa Developmental Disabilities Council, NAMI Iowa, ASK Resource Center, Area Agencies on Aging, County Case Management Services, and MHDS Regional Administrators.

3/9/2015 - 3/13/2015: Announcement of Public Comment Period - State released a White Paper, the Draft Transition Plan, and Draft Settings Analysis on the state website. Informational Letters were released and sent to all HCBS waiver providers, case managers and DHS service workers. Stakeholders (listed above) were contacted directly to inform them of the public comment period. A dedicated email address (HCBSsettings@dhs.state.ia.us) was established to receive public comments. Tribal notices were sent. Notices were filed in newspapers. Printed versions were made available in DHS local offices statewide, along with instructions on submitting comments via mail.
3/16/2015 - 4/15/2015: Public Comment Period for Proposed Transition Plan - State will share transition plan with the public in electronic and non-electronic formats, collect comments, develop state responses to public comments, and incorporate appropriate suggestions into transition plan. The Response to Public Comments document will be posted to the DHS website and a summary provided to CMS. Previous comment periods were held in May 2014 and November 2014 which included stakeholder forums.
4/15/2015 - 3/16/2019: Public Comment Retention - State will safely store public comments and state responses for CMS and public consumption.
4/15/2015 - 3/16/2019: Posting of Transition Plan Iterations - State will post each approved iteration of the transition plan to its website.
7/1/2015 - By 3/17/2019: Assessment Findings Report - State shares the findings of the onsite assessment annually by July 31.

Iowa HCBS Settings Analysis - This Settings Analysis is general in nature and does not imply that any specific provider or location is noncompliant solely by classification in this analysis. Final determination will depend upon information gathered through all assessment activities outlined in the transition plan, including but not limited to onsite reviews, provider annual self-assessments, IPES data, provider surveys, and GIS analysis.
Category: YES – Settings presumed fully compliant with HCBS characteristics
--Member owns the housing, or leases housing which is not provider owned or controlled.
Category: NOT YET – Settings may be compliant, or with changes will comply with HCBS characteristics
--Residential Care Facilities (RCFs) of any size
--Apartment complexes where the majority of residents receive HCBS
--Provider owned or controlled housing of any size
--Assisted Living Facilities
--Day program settings located in a building that also provides other disability-specific services, or where provider offices are located.

Category: NOT YET - Setting is presumed non-HCBS but evidence may be presented to CMS for heightened scrutiny review
--Located in a building that also provides inpatient institutional treatment
--Any setting on the grounds of or adjacent to a public institution
--Settings that isolate participants from the broader community
Category: NO – Settings do not comply with HCBS characteristics
--Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) (except Respite)
--Nursing Facilities/Skilled Nursing Facilities
--Hospitals
--Institutions for Mental Disease (IMD)

Public Comments Period:
Process:
Public comment was taken from March 16, 2015 through April 15, 2015. The transition plan was posted on the IME website at: https://dhs.iowa.gov/ime/about/initiatives/HCBS/TransitionPlans. The transition plan has been available at that location since March 12, 2015. Public notice in a non-electronic format was done by publishing a notice in major newspapers throughout the state; this notice was sent to the newspapers on March 9, 2015. The transition plan was available for non-electronic viewing in any of the 99 DHS office across the state for persons who may not have internet access. Comments were accepted electronically through a dedicated email address (HCBSsettings@dhs.state.ia.us). The address was provided for written comments to be submitted to the IME by mail or by delivering them directly to the IME office. Notice was also sent to the federally-recognized tribes on March 9, 2015.

Summary of Comments:
Comments that resulted in changes to the transition plan:
There were no comments received that resulted in changes to the transition plan.

Comments for which the State declined to make changes to the transition plan or settings analysis document:
There were numerous comments submitted which did not ask for changes to the transition plan, but rather were seeking clarification or interpretation of the federal regulation or posed operational questions about how the state would carry out activities in the transition plan.

Four commenters suggested that various aspects of the transition plan need to be updated to reflect the role that the Managed Care Organizations (MCOs) will have related to the Iowa High Quality Health Care Initiative. The state declined to makes changes based on the comment and explained in the response that Iowa plans to submit separate waiver amendments to make changes related to that effort in the near future, and that there will be another public comment period related to those amendments at that time.

Two commenters expressed concern about engaging consumers, families and advocates in the transition plan. The state declined to make changes based on the comment and explained the various ways that input from consumers and advocates has been sought in the development of the plan and expressed that consumer and advocate involvement will continue throughout implementation.

One commenter asked that the role of the state's Mental Health and Disability Services (MHDS) Regions be included in the plan. The state declined to make this change, explaining that the MHDS Regions are already listed as stakeholders in the plan.

One commenter asked that the plan be changed to eliminate the distinction between provider owned and controlled housing, as the commenter believed this had been eliminated from the regulation. The state declined to make this change and explained in the response that the federal regulation does still set out additional requirements for provider owned and controlled settings.

One commenter suggested that the "players" column which existed in an early draft of the transition plan, but was later removed should be added back into the plan. The state declined to make this change and explained in the response that the responsibility for completion of the activities listed in the transition plan lies with the IME, and other stakeholders are already noted in the description column for each item or in the explanatory narrative at the top of each section.

One commenter expressed that activities within the transition plan should not have end dates listed as "ongoing". The state declined to make this change and explained in the response that our approach utilizes an ongoing process of discovery, remediation, and improvement. As such, we are not performing a one-time statewide assessment that will result in a point-in-time list of settings that are compliant or non-compliant. Rather, our process will be a continuous cycle in which all settings will be assessed and remediated by the March 17, 2019 deadline, and our quality assurance processes will continue even after the transition deadline to assure that providers who were in compliance will continue to meet the requirements on an ongoing basis.

One commenter suggested that the actions or omissions that would trigger the requirement of a corrective action plan (CAP) should be listed in the transition plan. The state declined to make this change, explaining that any finding of noncompliance will trigger a CAP.

One commenter suggested that in regard to provider remediation, rather than the State allowing "reasonable time frames" for large infrastructure changes, the State should impose specific timeframes and deadlines. The state declined to make a change because we believe the commenter misunderstood the intent of the item. Our response to the comment explained that the timeframes that will be set out in any given CAP will be specific deadlines for that provider and location. The "reasonable timeframes" language needs to be read in the context of the previous sentence in the plan which indicates that in reviewing a CAP, the state will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Iowa High Quality Healthcare Initiative
Public Comment Summary

I. Background

The Iowa Department of Human Services (DHS) has continually sought to improve Medicaid and the Children's Health Insurance Program (CHIP) and beneficiary choice, accountability, quality of care, and health outcomes. DHS has also encouraged the provision of community-based services over institutional care where appropriate. The State seeks to build on its experience and improve the coordination of care, which is often available at different points throughout the Medicaid eligibility cycle and patient experience, through implementation of the Iowa High Quality Healthcare Initiative (Initiative). In recent months, this Initiative has also been referred to publicly as the Governor's "Medicaid Modernization Initiative."

The Initiative is intended to integrate care and gain efficiencies across the health care delivery system. In turn, the Initiative intends to decrease costs through the reduction of unnecessary and duplicative services. Under the Initiative, the majority of Iowa Medicaid beneficiaries will be enrolled in a managed care organization (MCO). MCOs are private health care organizations that provide and pay for health care services through an organized network of providers. MCOs use established guidelines to assure member services are appropriate and delivered at the right time, in the right way, and in the right setting. By contracting with MCOs for delivery of high quality health care services, beneficiaries' care will be better coordinated, resulting in improved access, quality, and health outcomes.

On February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative. This release was followed by the development of a dedicated web page, and a series of public meetings to discuss the Initiative (http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization). Stakeholders and members of the public were invited to attend meetings held in Cedar Rapids, Des Moines, Davenport, Iowa City, Council Bluffs, Mason City, and Sioux City. In total, close to 1,000 people attended and provided DHS with valuable comments and questions. This public engagement strategy was intended to solicit stakeholder feedback on key program design elements and MCO contract requirements. On March 26, 2015, the DHS released an amended version of the RFP which incorporated changes based on stakeholder feedback.

II. Federal Authorities

DHS is working with the Centers for Medicare and Medicaid Services (CMS) to obtain the necessary federal authority to implement the Initiative. This requires submission of a variety of federal Medicaid waivers and amendments, noted below.

§1915(b) Iowa High Quality Healthcare Initiative Waiver (New Waiver)
§1915(c) HCBS Intellectual Disabilities Waiver (Amendment)
§1915(c) HCBS Children's Mental Health Waiver (Amendment)
§1915(c) HCBS Elderly Waiver (Amendment)
§1915(c) HCBS Health & Disability Waiver (Amendment)
§1915(c) HCBS Physical Disability Waiver (Amendment)
§1915(c) HCBS Brain Injury Waiver (Amendment)
§1915(c) HCBS AIDS/HIV Waiver (Amendment)
§1115 Iowa Wellness Plan Demonstration Waiver (Amendment)
§1115 Family Planning Demonstration Waiver (Amendment)

Prior to submission of the aforementioned waivers, the State elected to conduct a public notice and comment process. At the beginning of this process, four of the State's §1915(c) waivers were pending review by CMS for matters unrelated to the Initiative. As such, the State has broken down the process into three "phases." However, managed care elements were consistent across all §1915(c) waivers. Notices, waiver documents, and information about the Initiative were posted online, and non-electronic copies were made available for review at DHS Field Offices, for each "phase." In addition, a summary notice was published in several newspapers with statewide circulation. The notice provided the option for any individual to submit written feedback to the State by email or by USPS mail.

Phase 1

Public notice for Phase 1 was provided on July 20, 2015, and included the following waivers: (1) §1915(b) High Quality Healthcare Initiative Waiver (New Waiver); (2) §1915(c) HCBS Intellectual Disabilities Waiver (Amendment); (3) §1915(c) HCBS Children's Mental Health Waiver (Amendment); (4) §1915(c) HCBS Elderly Waiver (Amendment); (5) §1115 Iowa Wellness Plan Demonstration Waiver (Amendment); and (6) §1115 Family Planning Demonstration Waiver (Amendment).

In addition, the State held four public hearings during Phase 1 to offer an opportunity for the public to provide written or verbal comments about the above-mentioned waivers. Hearings were held on July 27, 2015 (Bettendorf, IA), July 31, 2015 (Des Moines, IA), August 3, 2015 (Cedar Rapids, IA), and August 5, 2015 (Sioux City, IA). Toll free conference call capabilities were made available for the August 3rd and 5th dates in order to accommodate interested parties who were unable to attend a hearing in person. Hearings followed the same format, beginning with a brief presentation by State staff about the Initiative, a short question and answer session, and at least one hour of public comments. Time permitting, State staff fielded additional questions at the end of the hearing. The public comment period ended on August 24, 2015 (35-days from the date of publication), at which time comments were cataloged, summarized, and organized.

Phase 2

Public notice for Phase 2 was provided on August 14, 2015, and included: (1) §1915(c) HCBS Physical Disability Waiver (Amendment); and (2) §1915(c) HCBS Health and Disability Waiver (Amendment). Hearings were not held for the Phase 2 public comment period, as managed care descriptions for the waivers included in the published waivers (e.g., MCO roles and responsibilities) were the same as those published in Phase 1. Phase 2 ended on September 18, 2015 (35-days from the date of publication), at which time comments were cataloged, summarized, and organized.

Phase 3

Public notice for Phase 3 was provided on August 21, 2015, and included: (1) §1915(c) HCBS Brain Injury Waiver (Amendment); (2) §1915(c) HCBS AIDS/HIV Waiver (Amendment). Hearings were not held for the Phase 3 public comment period, as managed care descriptions for the waivers included in the published waivers (e.g., MCO roles and responsibilities) were the same as those published in Phase 1 and 2. Phase 3 will end on September 25, 2015 (35-days from the date of publication), at which time comments will be cataloged, summarized, and organized.

Tribal Consultation

The State also consulted with Iowa's federally recognized Indian tribes, Indian health programs, and urban Indian health organizations prior to submission of the waivers. Consultation was conducted in accordance with the process outlined in the State's approved Medicaid State Plan, and consisted of an electronic notice directed to Indian Health Service/Tribal/Urban Indian Health (I/T/U) Tribal Leaders and Tribal Medical Directors identified by the Iowa Indian Health Services Liaison. This notice was provided concurrently with notice of each phase described above and included a copy of the proposed amendment, along with a description of how and where to submit comments or questions.

III. Public Comments – Phase 1

Throughout the Phase 1 public comment period, a total of 162 questions and comments were received (51 questions, 42 verbal comments, and 69 written comments). Very few comments were waiver specific, as the vast majority were aimed at the Initiative in general. Of these questions and comments, a broad range of topics were addressed including case management, service delivery/access, home and community based services, MCO oversight/evaluation, eligibility/included benefits, provider issues, enrollment, member choice, outreach, implementation timeline, reimbursement, quality/safety, MCO standardization.

a. Program Questions

Comments Received:

During the public comment process, many individuals took the opportunity to ask questions related to program design and the implementation process. These questions were not specific to the Initiative or the waivers open for public comment; rather they sought clarification from the State. Individuals raised a variety of general questions around the following general themes: (1) 1915(c) HCBS waiver assessment process; (2) MCO selection, assignment and change processes and timelines; (3) implementation member outreach processes; (4) out-of-network providers policies and procedures around selecting a provider; (5) funding and authorization rules; (6) State MCO procurement process; (7) impact to eligibility; (8) clarification on the waiver public comment process; (9) provider roles and responsibilities; (10) reimbursement rates; (11) MCO operational processes; (12) case manager roles and qualifications; (13) MCO quality oversight processes; (14) level of care assessment procedures; (15) provider enrollment processes; and (16) clarification regarding FQCH & RHC reconciliation process and prospective payment system wrap payments.

§1915(b) Waiver Specific Questions:

In addition, to the above program-related questions several specific questions were raised requesting additions to the §1915(b) waiver: (1) ensure clarity regarding the 340B drug-pricing program; (2) allow all current Marketplace Assisters to provide state-supported services to Medicaid MCO beneficiaries; (3) include additional §1915(b)(3) services (e.g., telemedicine), as identified through a public input process; and (4) include a waiver measurement that addresses disparities by racial or ethnic group.

State Response:

Because the program questions did not provide specific feedback on the waivers, no modifications were made to the waivers. These general themes will be utilized by the State to continue developing communication materials and to inform the transition process. With respect to the 340B drug-pricing program, the State feels this would be best addressed through MCO contracting and will take the commenters suggestion into consideration during this process. Regarding Iowa Marketplace Assisters, the State views Assisters as valuable community partners. As such, the State will provide Assisters with information and education about the transition to managed care as part of the stakeholder engagement strategy. This information will provide the tools needed to help inform and refer Medicaid members the Assisters may have contact with to the Medicaid Enrollment Broker, Iowa Medicaid Enterprise Member Services (MAXIMUS). Finally, additional the State will take commenters request for the provision of additional §1915(b)(3) under advisement for future waiver amendments. The state will incorporate into its final waiver submission the recommended waiver measurement.

b. Case Management

Comments Received:

Several comments were received related to case management. Generally, commenters expressed the importance of case management being provided in a conflict free manner and without incentives for MCOs to cut services; several commenters perceived that case management provided through an MCO would not be conflict free. There were concerns that MCO case managers would not advocate for members and members were not guaranteed to have continued access to their current case manager. Commenters questioned if there would be enough qualified case managers to serve beneficiaries following the transition. Additionally, two current case managers raised concerns over their future employment status. Another commenter suggested the new program would provide an opportunity to improve the system that is currently difficult to navigate.

State Response:

The Initiative will continue case management services through the MCOs. MCOs are contractually required to ensure the delivery of services in a conflict free manner consistent with Balancing Incentive Program requirements and which administratively separates the final approval of service plans and approval of funding amounts. The State will approve and monitor all MCO policies and procedures through the readiness review and ongoing quality assurance processes, and ensure compliance and swiftly implement corrective actions in this area as needed. With respect to the number of qualified case managers available to provide services following implementation, DHS anticipates that the overall number of Medicaid beneficiaries will not materially change during the transition to managed care and that the overall system will continue to have the capacity to provide case management services to all beneficiaries regardless of delivery mechanism (i.e., managed care or fee-for-service), as they do today. The implementation plan for the Initiative allows members to retain their current case manager during the first six months of transition, regardless of whether the MCO has an agreement with the member's existing case manager. Following this six-month period, MCOs must provide advance notice of planned case manager changes, and

must ensure continuity of care when such changes are made. For those beneficiaries remaining in fee for service, DHS will maintain existing contracts to ensure sufficient numbers of case managers are available to meet the needs of beneficiaries.

c. Service Delivery/Access

Comments Received:

Several comments were received related to service delivery and access. Generally, commenters expressed concern that MCOs may prioritize profit over services, which will jeopardize member health and safety, and that members with disabilities and/or serious health conditions may no longer receive the attention and care they require. One commenter expressed support that MCOs would be required to contract with the current Medicaid providers. Finally, one commenter suggested that the State extend the transition of care period (i.e., the period during which patients are allowed to keep their existing provider) from six months to a year.

State Response:

The Initiative has been designed to incorporate mechanisms to ensure State funding to MCOs is spent on the delivery of services to enrollees and that quality outcomes are achieved. For example, home and community based services waiver metrics include, among other things, an assessment of whether enrollees received the all of the services outlined in their plan of care and a review of whether waiver provider enrollment applications were verified against appropriate licensing and/or certification agencies. Further, the State may require corrective action(s) and implement intermediate sanctions depending upon the nature, severity, and duration of the deficiency, and repeated nature of the non-compliance. Additionally, MCOs will have a portion of their State payments withheld; payment of the withhold amount can only be obtained by the MCO if it achieves defined quality outcomes. The State will also establish escalating targets for each quality measure in future years of the program. This means if MCOs do not achieve better results each year they will not be eligible for payment of their withheld amounts. Additionally, the State has established a medical loss ratio (MLR) to ensure State funding is spent on the delivery of services to members. An MLR caps the portion of State dollars that can be spent by the MCO on non-healthcare related services such as administration, marketing, and profits. The State will recoup funding if an MCO does not meet the required MLR. No changes have been made to the waivers as a result of these comments. With respect to extending the transition of care period, the State will be monitoring and assessing provider networks on an ongoing basis post implementation to ensure that beneficiaries' continuity of care for beneficiaries transitioning to managed care, as well as ongoing member access.

d. Home and Community Based Services (HCBS)

Comments Received:

Multiple comments were received related to the provision of home and community based services (HCBS). Commenters expressed the importance of emphasizing HCBS over institutional services. They indicated there should be requirements and incentives for MCOs to move the State toward supporting community integration and suggested future cost savings be used to increase access to HCBS. However, it was also noted that there are access issues for community-based services that will prevent such movement. Also related to access, one commenter expressed concern that provider access would be compromised if MCOs were allowed to limit HCBS providers. Further, one commenter was concerned the Initiative would strive to move enrollees to individual apartments and out of group homes. One commenter also questioned how individuals residing in group homes would be impacted if residents were enrolled with different MCOs.

Commenters also discussed the importance of MCOs involving and partnering with family caregivers for HCBS waiver enrollees. Support for the Consumer Choices Option was expressed and individuals wanted this maintained under managed care.

Multiple comments were received related to HCBS waiver waiting lists. Specifically, commenters suggested waiver waiting lists be eliminated, or additional waiver slots added. Alternatively, it was proposed waiver enrollees be excluded from managed care until there is no waiting list. Another commenter raised the concern the MCOs would eliminate waiver slots. One commenter expressed concern with the current process for managing the waitlist and suggested individuals have a functional assessment completed upfront to prevent ineligible individuals from being placed on the waiting list. Other commenters indicated HCBS waiver enrollees should be excluded from managed care enrollment; they pointed to current strategies, which already manage waiver enrollee care, such as proposed rules for implementing budget caps.

Comments were received regarding provider types that should be eligible HCBS waiver providers. Commenters indicated Home Care Agencies should be added as an eligible provider type, which includes providers who meet the definition of an

authorized provider under 641 Iowa Administrative Code 80.2(135). Another commenter indicated language regarding home care agencies should be removed, as IDPH is no longer contracting for homemaker services. Additionally, one commenter suggested the Area Agencies should not be allowed to provide services in areas where there are at least two other providers and that having the Area Agencies maintain case managers is a conflict of interest. Another commenter suggested Medicare/Medicaid certification should not be required to provide homemaker services to members. Further, comments were received related to the assessment process. One commenter indicated members already undergo extensive assessments and the results of those should be used. Another commenter expressed concern over the perception that the assessment process would no longer be uniform. Another commenter noted that the waiver and MCO request for proposals do not reference 441 Iowa Administrative Code Chapter 24, and that the amount of time a waiver enrollee is visited does not match the current regulation. Finally, one commenter expressed concern that Integrated Health Homes and BHIS were not mentioned in the waivers.

Children's Mental Health Waiver Specific Comments:

One commenter requested that the consumer choices option (CCO) be added to the waiver.

Elderly Waiver Specific Comments:

One commenter requested that the Appanoose Community Care Services be eligible to enroll as a service provider for homemaker and personal emergency response systems. Another commenter requested the addition of shared living and adult foster care as covered services under the Elderly Waiver. One commenter indicated the following language should be changed; however, the State is unable to make such a change as this is language from the Centers for Medicare and Medicaid Services (CMS) preprint application: "[t]he State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver," should be revised to "will be taken," as the State does not have standards for direct caregivers." This commenter also indicated the lifetime limit for a home modification is not realistic and MCOs should be provided additional flexibility.

ID Waiver Specific Comments:

Comments were received indicating that with the ID waiver accounting for the majority of HCBS waiver spending and new rules being promulgated to cap budgets managed care does not seem necessary.

State Response:

The State shares commenters' commitment to the emphasis on HCBS versus institutional care. This is one benefit of managed care as incentives are provided to move individuals into the community; as such, the number of individuals served under the waivers is projected to increase under the Initiative. The Initiative also strives to support and increase HCBS provider access; MCOs are held accountable for meeting contractual requirements for HCBS access standards and must authorize out-of-network care when it cannot be provided in-network. Additionally, DHS concurs with commenters' support of the Community Choices Option; as such, this is a key component of the program that MCOs must implement. While the State appreciates the concerns raised regarding inclusion of §1915(c) waiver enrollees, our belief is managed care will provide better integrated care with one single entity responsible for providing all services, including LTSS. Further, while we agree there are current management mechanisms in place for waiver enrollees, the Initiative will build upon such strategies.

With respect to eligible HCBS waiver providers, these categories are established in the Iowa Administrative Code and can only be changed through the administrative rulemaking process. The State will review and consider amendments to the list of eligible HCBS waiver providers in future rulemaking. Further, providers serving Medicaid beneficiaries, regardless of delivery system, must be enrolled with Iowa Medicaid. These certification and enrollment processes help assure qualified individuals are rendering services and provide member protections.

Regarding the references to 441 Iowa Administrative Code Chapter 24, this particular set of rules establishes case management enrollment criteria. MCOs will be required to meet the expectations in 441 Iowa Administrative Code Chapter 90, which sets forth rules for case management, including service plan requirements.

Regarding comments received on the assessment process, it appears there has been some misunderstanding regarding how the assessment process will occur under managed care. The current functional assessment tools will remain in use and MCOs cannot revise or add to the tools without express approval from the State. To the extent the State would consider proposed revisions or additions, consensus among MCOs and stakeholder engagement would be sought.

Finally, regarding the concern raised that lifetime limits should not apply to home modifications on the Elderly Waiver, as

described in Appendix C of the waiver, there is a mechanism through the Exception to Policy process for requests to be reviewed when a member's need exceeds the lifetime limit. Further, no changes were made to the covered benefits under the waiver due to the implementation of managed care. However, MCOs will have the flexibility to provide enhanced services with DHS approval.

e. MCO Oversight/Evaluation

Comments Received:

Several comments were received related to MCO oversight and evaluation. Generally, commenters suggested this should be conducted by an independent entity and that results should be made publically available. One commenter suggested there should be more focused quality and pay-for- performance measures related to children's health. Commenters suggested a range of measures and factors that should be reviewed and monitored, such as network adequacy, audits of MCO claims payments, grievances and appeals, and healthcare quality outcomes. One commenter suggested the MCOs should be required to use a consistent quality measurement process.

State Response:

The State has implemented a comprehensive oversight strategy consisting of elements such as: (1) an MCO readiness review conducted by an independent entity prior to member assignment; (2) an annual external quality review; (3) an independent assessment in accordance with the §1915(b) waiver; (4) a pay-for-performance program; (5) contractual non-compliance remedies; (6) use of an Ombudsman; and (7) various quality monitoring strategies and metrics as outlined in each waiver and the MCO contracts. In addition the State is obligated to provide regular reports to CMS for §1115 Demonstration projects and §1915 HCBS waivers.

Pursuant to State legislation (Senate File 505), the Iowa Department of Human Services (DHS) will also be conducting monthly statewide public meetings, beginning March 2016, to gather input from members, stakeholders, providers, community advocates and the general public on the managed care transition and implementation. All comments will be compiled and shared with the Iowa Medical Assistance Advisory Council (MAAC), which serves as an advisory forum on the health and medical care services provided under Medicaid. The MAAC Executive Committee will be responsible for assessing feedback received and making formal recommendations to the Iowa Department of Human Services. The Executive Committee meets monthly and consists of members from both professional and consumer organizations, as well as the general public. Current organizational representation of the Executive Committee includes the Iowa Department of Public Health, the Iowa Hospital Association, the Iowa Health Care Association/Iowa Center for Assisted Living, the Iowa Medical Society, the Iowa Association of Community Providers, the Iowa Pharmacy Association, AARP, the Coalition for Family and Children's Services in Iowa, the Iowa Association for Area Agencies on Aging, and NAMI Iowa.

No changes related to the MCO monitoring, oversight or quality assessment related portions of the waivers were made as a result of these comments.

f. Eligibility/Included Benefits

Comments Received:

Several comments were received related to populations eligible for managed care. One commenter suggested the State exclude individuals who rely on plasma protein therapies or alternatively to allow such users to maintain access to current specialists and therapies. Another commenter expressed concern about the inclusion of individuals with mental health issues. A third commenter suggested the State change its position to require all MCOs to carve in Medicaid managed care prescriptions and other products into the 340B drug-pricing program. One commenter perceived the exclusion from managed care enrollment during a member's retroactive eligibility period as elimination of retroactive eligibility. Finally, one commenter suggested the State require MCOs to extend non-emergency transportation (NEMT) services to all patients, regardless of the individual Medicaid coverage program for which they qualify.

State Response:

The State has opted not to modify the eligibility criteria for managed care enrollment. MCOs are contractually bound to continuity of care requirements to prevent disruption for individuals reliant on plasma protein therapy. Further, the delivery of behavioral and physical health services by a single entity will promote coordinated care that addresses the full healthcare needs of members versus the current system which silos mental health and primary care. As a point of clarification for commenters, the State has not requested a waiver of retroactivity. Rather, individuals will simply not be enrolled in managed care during

this time period and any costs incurred during retroactive periods will be reimbursed through fee-for-service. Finally, pursuant to an agreement with CMS, the State has conducted an analysis of Medicaid member survey responses on difficulties with transportation for beneficiaries subject to the Iowa Health and Wellness Plan (IHAWP) NEMT waivers as compared to survey responses of persons who have access to NEMT services. Findings of this analysis suggest there was not a statistically significant difference between the two populations; however, CMS requested an additional study supporting more granular analysis capability. As a result, the State was allowed to continue to waive NEMT services for members receiving coverage under the IHAWP (who are not medically exempt and who are not eligible for EPSDT services) through March of 2016, while additional data is gathered and analyzed.

g. Provider Issues

Comments Received:

Another theme noted among comments was the impact of the Initiative on providers and in turn the importance of ensuring sufficient provider training. One commenter requested more detailed information be included in the waivers about how the MCOs will invest and continue to build and offer new payment relationships in partnership with providers.

Some comments were received related to medical professionals versus MCOs being best suited to determine a patient's care plan and whether or not the prudent layperson standard for emergency services is met. Further, it was suggested that the State should require every patient to be assigned a primary care provider (PCP), versus the current requirement that requires a minimum of 40% of the MCO's population be in a value-based purchasing arrangement with an assigned PCP by 2018.

The concern was raised that managed care savings would come at the expense of providers. Further, one commenter noted his staff will be required to devote time to working with MCOs, a service which will not be reimbursable. Similarly, it was suggested any providers currently credentialed under Medicaid should be automatically credentialed by the MCOs. Finally, one commenter recommended the claims submission timeline be expanded.

State Response:

The State concurs that provider training will be imperative to ensure a smooth transition; plans have been developed to address provider communications, outreach and training. Further, we appreciate the request that more detailed information be provided regarding MCO strategies to develop new payment partnerships with providers; as MCO contracts have been recently awarded, these types of details can begin to be provided. The State recognizes that provider education is critical to successful implementation of the Initiative. On August 20, 2015 the State announced that it would be offering live provider education sessions on the transition to managed care in eleven different communities throughout the State during the Month of September. In an effort to meet the anticipated demand for information, the same training session will be offered twice in each community where it is presented.

Regarding the authorization of services, MCO practice guidelines must be developed based on valid and reliable clinical evidence or consensus of healthcare professionals in the particular field. Further, MCOs are required to assure appropriate clinical expertise and training to interpret and apply the utilization management criteria and practice guidelines and must consult with the requesting provider when appropriate. The MCOs must document access to board certified consultants to assist in making medical necessity determinations and any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested must be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease, or in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.

The State concurs that developing streamlined processes, such as credentialing, will be useful in some cases to minimize provider burden. However, automatic deeming of current Medicaid providers will not be implemented. To support quality, the MCOs are required to maintain national accreditation; therefore, the MCOs must maintain credentialing and re-credentialing processes that meet the standards of the accreditation entity.

h. Enrollment

Comments Received:

Several comments were received related to member enrollment. Generally, commenters expressed concern that they do not understand how the enrollment process will work, specifically whether they will have a choice in selecting MCOs, whether they will be allowed to change following enrollment and how the auto-assignment algorithm would operate. Comments

revealed there was some misperception regarding how the implementation enrollment process would occur. The importance of sufficient member outreach and use of an unbiased Enrollment Broker during the implementation enrollment period was stressed by commenters. One commenter indicated it was important individuals eligible for both MCO and Program of All-Inclusive Care for the Elderly (PACE) enrollment be presented with the option to enroll in either program. Some commenters perceived the tentative assignment process as limiting member choice and creating the perception that assignment has already been made, as described in further detail in the Member Choice section below.

State Response:

The State will continue efforts to increase beneficiary understanding of the enrollment process. Communication efforts will be ramping up now that the MCOs have been selected. The State's goal is to ensure a seamless transition for current beneficiaries and to provide ample opportunity for informed decision-making regarding MCO selection. The tentative assignment process is intended to advise members of which MCO they will be assigned to in the absence of a choice; this will provide clarity on what will occur if contact to the State is not made regarding an alternative choice. Further, the State will utilize an independent Enrollment Broker to assure no conflict of interest in the MCO enrollment and choice counseling process. The option for PACE enrollment will also be provided.

i. Member Choice

Comments Received:

Several comments were received related to member choice of MCO. In general, these commenters expressed concern that the State's proposed process to facilitate MCO selection through tentative assignment would reduce member choice. One commenter indicated that institutionalized beneficiaries would be given a choice of MCO before assignment, whereas non-institutionalized beneficiaries would not be given a choice of MCO before assignment. Another commenter suggested that in the event that two MCO options are not available, a consumer should have the opportunity to request an alternative option to receive services and that in the event a designated MCO is not providing the necessary and appropriate services, the consumer should be able to request to change MCOs.

State Response:

The proposed tentative assignment process is intended to facilitate a smooth transition between delivery systems and to provide numerous opportunities for members to make informed choices regarding MCO enrollment. As described in the published waivers, the State will begin accepting MCO selections from current Medicaid beneficiaries beginning in fall 2015. Members will receive a tentative, or preliminary, assignment that takes into consideration such factors as related family member assignment, and geographic considerations. Once receiving this tentative assignment, members will have an opportunity to choose another MCO prior to the assignment becoming effective, with the support of an independent Enrollment Broker. A member's MCO assignment for January 2016 will become effective on December 17, 2015 based on their tentative assignment if an alternative choice is not made. Members will also have ninety days to change MCOs without cause after the assignment or member choice is effective. Finally, all members may change their MCO annually and may disenroll for certain good cause reasons.

While the State will not be amending the proposed tentative assignment process, it will consider implementing several commenters' operational recommendations. Specifically, enrollment notices will be presented to members in a way that sets forth enrollment options first, and then describes the tentative assignment process. This is intended to assist members to understand their right to select the MCO that best meets their needs. Further, samples notices will be sent providers, including case managers, via the Individualized Services Information System (ISIS) and through Informational Letters to assist with disseminating information. Finally, the State will investigate the feasibility of conducting member interviews to assess the whether there is an enrollment manipulation.

j. Outreach

Comments Received:

Several comments were received related to member outreach. In general, these commenters felt the State should solicit greater stakeholder input in developing the Initiative and that members were unaware of the implications of the transition to managed care. One commenter suggested the State monitor the effectiveness of the oversight committee and public meetings, and make modifications to the Initiative as needed. Another commenter suggested that the state establish an open enrollment period.

State Response:

The State has developed a robust communication and education plan regarding the Initiative. On February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative. This release was followed by the development of a dedicated web page, various meetings with stakeholder committees and organizations, as well as a series of public meetings to solicit feedback on key program design elements and MCO contract requirements. Stakeholders have also had the opportunity to comment on the Initiative through the public notice and hearing process, during which time stakeholders were invited to review waiver documents, provide comment, and ask questions of State staff. Finally, the State has regularly issued press releases, "Frequently Asked Questions" documents, fact sheets, and presentation documents to help inform the public and to facilitate an ongoing dialogue regarding the Initiative.

While the State will not be amending the proposed waivers, it will be adopting several commenters' recommendations. Specifically, the State will continue to work with member advocacy organizations to communicate the transition to members and to ensure they understand its impact. In addition, the State will begin facilitating training sessions for providers over the coming months to ensure continuity of care and reimbursement under the Initiative. Finally, during the enrollment process, the State will review and work to update its HCBS enrollee database to facilitate effective transmission of information.

k. Implementation Timeline

Comments Received:

Several comments were received related to the implementation timeline for the Initiative. In general, these commenters felt the implementation date of January 1, 2016 may be aggressive, could jeopardize member health and safety, could cause claims processing issues, and may not allow time for MCOs to establish provider networks. Recommendations have been made to postpone implementation to at least July 1, 2016, and/or to proceed with a "phased" approach ending with HCBS Waiver enrollees.

State Response:

The State has implemented multiple strategies to assure beneficiary continuity of care will be achieved as part of the implementation and is committed to maintaining the existing timeline for implementation. To begin with, a comprehensive readiness review process will be established to ensure that all MCOs are prepared to initiate operations prior to January 1, 2016. This process will assess the MCOs' capability to provide services in accordance with their contract in areas such as, maintaining provider networks, processing service authorizations, and paying claims within contractually required timeframes. No MCO will be permitted to enroll members without meeting the State's expectations for readiness. Finally, the State has selected MCOs with demonstrated experience serving Medicaid enrollees, and that are well positioned to help the State achieve its goals under the Initiative.

l. Reimbursement

Comments Received:

Several comments were received related to MCO and provider reimbursement. With respect to MCOs, commenters suggested that the State conduct audits of payments to MCOS to ensure plan compliance and performance. One commenter suggested that the established rates were not actuarially sound and were not developed according to CMS guidelines. Concerning providers, commenters suggested that the State increase current reimbursement rates, that critical access hospitals continue to be paid on a cost-basis, that MCOs be required to make per-member/per-month payment to primary care providers, and that MCOs pay providers at a level not less than the most recent DRG base rates for inpatient services and the most recent MAPC rates for outpatient services. Two commenters also suggested the State's limitation of indirect administrative costs to 23% under 441 Iowa Administrative Code 79.1(d)(3) (i.e., methodology for determining the reasonable and proper cost for fee-for-service providers of case management) was too high. Finally, several commenters supported the State's efforts to preserve the Hospital Assessment program during implementation of managed care.

State Response:

Rates established for the Initiative meet the rate-setting criteria established by the CMS, have been certified as being actuarially sound, and will be provided to CMS for review and approval. Further, the proposed medical loss ratio requires that MCOs spend at least 88% of premium dollars on medical care (i.e., at least $0.88 of every premium dollar must be spent on medical care, while the remaining $0.12 can go toward administration and profits). This not only consistent with the majority of states implementing managed care, it also meets the standard set forth in the recently proposed CMS rule regarding

Medicaid managed care (CMS-2390-P).

MCOs are required to reimburse all in-network provider types at rates that are equal to or exceed the Agency designated floor for current Iowa Medicaid fee-for-service rates. These rates are established pursuant to 441 Iowa Administrative Code 79.1. Generally, institutional providers are reimbursed on a prospective or retrospective cost-related basis, and practitioners are reimbursed according to a fee schedule. The latter are determined with advice and consultation from appropriate professional groups and are increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved. Fee schedules in effect for the providers covered by fee schedules can be obtained at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule. Payment levels for fee schedule providers of service may be altered upon direction of the Iowa Legislature through Medicaid appropriations. All provider rates are part of Iowa Administrative Code and are subject to public notice and comment any time there is change.

Finally, MCOs must establish performance-based incentive systems for their contracted providers, subject to State approval prior to implementation and before making any changes to an approved incentive. Incentive programs will be structured to encourage positive member engagement and health outcomes that are tailored to health issues prevalent among enrolled membership. The MCOs must provide information concerning its physician incentive plan, upon request, to its members and in any marketing materials in accordance with the disclosure requirements stipulated in federal regulations.

m. Quality/Safety

Comments Received:

Several comments were received related to the quality of services provided to beneficiaries following the transition to managed care. Generally, commenters felt that the current delivery system was capable of providing higher quality services to beneficiaries.
State Response:

Increasing the quality of care and improving health outcomes for all beneficiaries is the primary goal of the Initiative. As such, MCOs are contractually obligated to, and will be held accountable for, improving quality outcomes and developing Quality Management/Quality Improvement (QM/QI) programs with objectives that are measurable, realistic and supported by consensus among the MCO's medical and quality improvement staff. Through the QM/QI program, MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to its members. Quality information must be made available to members based on their preferred method of communication. As a key component of its QM/QI program, MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving health outcomes. All QM/QI programs are subject to state approval. Further, all MCOs will be assessed according to standards established by the State and are required to provide all information and reporting necessary to complete this assessment. In accordance with federal law, the State will regularly monitor and evaluate MCO compliance with the standards established by the State and the MCOs QM/QI program. Finally, MCOs will be required to attain and maintain accreditation through the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC). In the event an MCO fails to attain and maintain accreditation in the required timeframe, the MCO must submit a formal corrective action plan for State review and approval.

Separate for the above considerations, Iowa was one of eleven states awarded a State Innovation Model (SIM) grant to test whether quality and value oriented healthcare reforms could produce superior results when implemented in the context of a state-sponsored Plan. The $43 million grant was announced in December of 2014, and was incorporated into Iowa's managed care approach via specific requirements for Value Based Purchasing (VBP) and a common quality measurement tool, called the Value Index Score (VIS) that is used across delivery systems. Because the VIS measures quality at a population health level, it ensures MCO savings is linked to whole-system improvement supporting all members, not just managing isolated pockets of opportunity within the Medicaid population. This initiative is a multi-payor strategy that aligns Medicaid with Wellmark Blue Cross and Blue Shield (specifically) and Medicare (more generally) bringing the scale necessary to influence real delivery system reform across the state.

Finally, the Initiative has been designed to provide high quality health care and create a level of accountability that does not exist today. The State will conduct ongoing reviews of MCO accreditation requirements to ensure standards are maintained. Further, the State monitor MCOs on a variety of key metrics on an on-going basis (e.g., provider network and access standards).

n. MCO Standardization

Comments Received:

Several comments were received related to the standardization of processes across MCOs and concern that variations may be cumbersome for providers. For example, recommended areas of alignment included: (1) primary care provider assignment and algorithms; (2) quality and performance measures; (3) approach to processing, analyzing, and sharing claims and other data with providers; (3) consistent approaches to value based contracting with providers; (4) provider credentialing and application processes; (5) prior authorizations/approvals forms and processes; (6) prescription management; (7) program requirements for chronic conditions and integrated health homes; (8) utilization management processes; (9) health risk assessment tools; and (10) processes to identify 340B claims.

State Response:

The commercial market does have variation across health plans for different operational processes so some variation is to be expected. The MCOs are required to provide training to providers on key procedures and the State will monitor key processes after the Initiative is implemented and consider adjustments if necessary. The state will also collaborate with the MCOs to ensure that processes are developed as consistently and efficiently across MCOs as possible. In addition, common approaches may be leveraged to support overarching goals, such as the required use of VIS across all MCO's as a standard to measure delivery system quality within value based purchasing.

o. Tribal Consultation

Only one question was received asking whether I/T/U providers would be required to enroll with an MCO in order to receive reimbursement for services rendered to American Indian/Alaska Natives (AI/AN) who opt to enroll in managed care through the Initiative. The State informed this provider that he/she, whether participating in the network or not, will be paid for covered Medicaid or CHIP managed care services provided to AI/AN enrollees who are eligible to receive services either: (1) at a rate negotiated between the managed care entity and the provider; or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider. Further, the State will operate in compliance with the provisions of the American Recovery and Reinvestment Act and CMS guidance.

IV. Public Comments – Phase 2

An additional 22 questions and comments were received between the end of Phase 1 and the end of Phase 2 (10 questions and 12 written comments). One comment was waiver specific, and the remaining 21 addressed the Initiative in general. Of these questions and comments, a broad range of topics were addressed including service delivery/access, home and community based services, MCO oversight/evaluation, implementation timeline, and quality/safety.

a. Program Questions

Comments Received:

As seen during Phase 1, many individuals took the opportunity to ask questions related to program design and the implementation process. These questions were not specific to the Initiative or the waivers open for public comment; rather they sought clarification from the State. Individuals raised a variety of general questions around the following general themes: (1) provider reimbursement rates and billing processes; (2) member services/benefits (e.g., prevocational waiver, habilitation, dental, mental health, integrated health homes); (3) MCO operational processes; (4) beneficiary outreach; (5) state planning assumptions and financial projections; (6) provider enrollment; and (7) provider caseloads.

State Response:

Because the program questions did not provide specific feedback on the waivers, no modifications were made to the waivers; however, these general themes will be utilized by the State to continue developing communication materials and to inform the transition process. Further, the State recognizes that provider education is critical in successfully implementing the Initiative. As providers submitted a number of the above referenced questions, many have been incorporated into the State's Annual Provider Training. These provider education sessions are being offered in eleven different communities throughout the State in September and will focus primarily on discussions regarding the Initiative. The information will also be incorporated into any future provider training or webinar sessions.

b. Service Delivery/Access

Comments Received:

Two comments were received related to service delivery and access. One commenter expressed concern that data is lacking to support claims that managed care will reduce costs and that the Initiative will result in a reduction of services, particularly behavioral health services.

Health and Disability Waiver:

One commenter expressed concerned that the Initiative would limit enrollees ability to access already established teams of waiver providers if they are not part of an MCO's network, and that this was of particular concern for those living in rural areas.

State Response:

As noted in the State's Phase 1 response to similar comments, the Initiative has been designed to incorporate mechanisms to ensure State funding to MCOs is spent on the delivery of services to enrollees and that quality outcomes are achieved. For example, the State has established a medical loss ratio (MLR) to ensure State funding is spent on the delivery of services and to cap the portion that can be spent by the MCO on non-healthcare related services such as administration, marketing, and profits. With respect to specialist provider access, the Initiative strives to support and increase HCBS provider access. As such, MCOs will be held accountable for meeting contractual requirements for HCBS access standards and must authorize out-of-network care when it cannot be provided in-network. No changes have been made to the waivers as a result of these comments.

c. Home and Community Based Services (HCBS)

Comments Received:

Three comments were received related to the provision of home and community based services (HCBS). One commenter requested that supported community living and job coaching be added to all HCBS waivers as a service for children to support their independence and employment. The second commenter expressed concern about the effect of HCBS waiting lists generally. The third commenter requested that children on HCBS waivers be exempt from mandatory enrollment in managed care.

State Response:

The State shares commenters' commitment to supporting all HCBS waiver recipients, including children, in achieving greater independence. Hence, MCOs will have the flexibility to provide enhanced services, subject to DHS approval. While no changes were made to the covered benefits under the waiver at this time due to the implementation of managed care, the State will consider the commenter's request for future amendments. With respect to waiting lists, the State will continue to emphasize HCBS versus institutional care. This is one benefit of managed care as incentives are provided to move individuals into the community; as such, the number of individuals served under the waivers is projected to increase under the Initiative. Finally, the State that believes quality and outcomes for all Medicaid beneficiaries, regardless of age, will be improved under managed care, as there will be a single entity coordinating care. In addition, choice for children will be maintained through a variety of mechanisms including, but not limited to, choice of MCO, choice of healthcare providers, and ability to change MCO.

d. MCO Oversight/Evaluation

Comments Received:

Several comments were received related to MCO oversight and evaluation. Generally, commenters expressed concern that selected MCOs had been fined in other states for contractual issues.

State Response:

The MCOs were selected through a competitive procurement process. They underwent a rigorous review process and were assessed on a variety of factors related to their experience and demonstrated success in serving Medicaid enrollees. Further, as described in the Phase 1 responses, the State will be implementing a comprehensive ongoing MCO monitoring process. As such, no changes related to the MCO monitoring, oversight or quality assessment related portions of the waivers were made as a result of these comments.

e. Implementation Timeline

Comments Received:

One comment was received related to the implementation timeline for the Initiative. In general, this commenter felt the implementation date of January 1, 2016 was too aggressive and would jeopardize member health and safety.

State Response:

As noted in the State's Phase 1 response to similar comments, the State has implemented multiple strategies to assure a safe and seamless transition, and is committed to maintaining the existing timeline for implementation. Not only will the State conduct a comprehensive readiness review process to assess MCOs' capability to provide services in accordance with their contracts, no MCO will be permitted to enroll members without meeting the State's expectations.

f. Quality/Safety

Comments Received:

Several comments were received related to the quality of services provided to beneficiaries following the transition to managed care. Generally, commenters felt that the Initiative would result in higher costs and decreased benefits.

State Response:

As noted in the State's Phase 1 response to similar comments, MCOs are contractually obligated to, and will be held accountable for, achieving quality outcomes. MCOs will also be regularly assessed according to standards established by the State, and will be required to attain and maintain accreditation through the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC). Finally, the State monitor MCOs on a variety of key metrics on an on-going basis (e.g., provider network and access standards).

g. Tribal Consultation

No questions or comments were received regarding the Phase 2 waivers.

Appendix A: Waiver Administration and Operation

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

   (●) **The waiver is operated by the State Medicaid agency.**

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

   (●) **The Medical Assistance Unit.**

   Specify the unit name:
   Bureau of Long Term Care, Iowa Medicaid Enterprise
   (Do not complete item A-2)

   ( ) **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

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

   (Complete item A-2-a).

   ( ) **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

Appendix A: Waiver Administration and Operation

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

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   MCOs will generally be responsible for delivering covered benefits, including physical health, behavioral health and LTSS in a highly coordinated manner. Specific functions include, but are not limited to, the following:

   - Developing policies and procedures for ongoing identification of members who may be eligible for waiver services;
   - Conducting comprehensive needs assessments, developing service plans, coordinating care, and authorizing and initiating waiver services for all members;
   - Conducting level of care reassessments with IME retaining final review and approval authority for any reassessments which indicate a change in the level of care;
   - Delivering community-based case management services and monitoring receipt of services;
   - Contracting with an entity or entities for financial management services to assist members who elect self-direction (i.e., Iowa's "Consumer Choices Option");
   - Maintaining a toll-free telephone hotline for all providers with questions, concerns, or complaints;
   - Maintaining a toll-free telephone hotline for all members to address questions, concerns, or complaints;
   - Operating a 24/7 toll-free Nurse Call Line which provides nurse triage telephone services for members to receive

medical advice from trained medical professionals;
- Creating and distributing member and provider materials (handbooks, directory, forms, policies and procedures, notices, etc.);
- Operating an incident reporting and management system;
- Maintaining a utilization management program;
- Developing programs and participating in activities to enhance the general health and well-being of members; and
- Conducting provider services such as network contracting, credentialing, enrollment and disenrollment, training, and claims processing.

Those participants who have not made an MCO selection, or who are otherwise ineligible for managed care enrollment as defined in the Iowa High Quality Healthcare Initiative §1915(b) waiver, will continue to receive services through the fee-for-service delivery system. As such, the State will continue to contract with the following entities to perform certain waiver functions.

IME contracts with Child Health Specialty Clinics (CHSC) through the University of Iowa. CHSC provides nurse consultants and parent navigators to provide consultation, technical assistance, planning, and care coordination activities related to agencies and participants under the age of 21 with complex and special health care needs, and who are recipients of the HD Waiver.

Member Services (Maximus) as part of a contract with IME to disseminate information to Medicaid beneficiaries and provide support. Additionally, Member Services provides clinical review to identify beneficiary population risks such that additional education, program support, and policy revision can mitigate risks to the beneficiary when possible.

Medical Services Unit (MSU) (Telligen) conducts level of care evaluations and service plan development ad-hoc reviews to ensure that waiver requirements are met. In addition, MSU conducts the necessary activities associated with prior authorization of waiver services, authorization of service plan changes and medical necessity reviews associated with Program Integrity and Provider Cost Audit activities.

Home and Community Based Quality Assurance (Telligen) reviews provider compliance with State and federal requirements, monitors complaints, monitors critical incident reports and technical assistance to ensure that quality services are provided to all Medicaid members.

Program Integrity and Recovery Audit Coordinator (Optum) reviews provider records and claims for instances of Medicaid fraud, waste, and abuse. These components are evaluated and analyzed at an individual and system level through fraud hotline referrals and algorithm development.

Provider Services (Maximus) coordinates provider recruitment and executes the Medicaid Provider Agreement. The Provider Services Unit conducts provider background checks as required, conducts annual provider trainings, supervises the provider assistance call center, and manages the help functions associated with the IME's Individualized Services Information System (ISIS).

Provider Cost Audit (Myers and Stouffer) determines service rates and payment amounts. The Provider Cost Audit Unit performs financial reviews of projected rates, reconciled cost reports, and performs onsite fiscal reviews of targeted provider groups.

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

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

Point-of-Sale (POS) (Gould Health Systems) is the pharmacy point of sale system. It is a real-time system for pharmacies to submit prescription drug claims for Iowa Medicaid beneficiaries and receive a timely determination regarding payment.

All contracted entities including the Medicaid Department conduct training and technical assistance concerning

their particular area of expertise concerning waiver requirements. Please note that ultimately it is the Medicaid agency that has overall responsibility for all of the functions while some of the functions are performed by contracting agencies. In regards to training, technical assistance, recruitment and disseminating information, this is done by both the Medicaid agency and contracted agencies throughout regular day-to-day business.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
IME Medical Policy Staff, through DHS, is responsible for oversight of the contracted entities. The DHS IME is the State Agency responsible for conducting the operational and administrative functions of the waiver.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
IME is an endeavor that unites State Staff and "Best of Breed" contractors into a performance-based model for the administration of the Iowa Medicaid program. The IME is a collection of specific units, each having an area of expertise, and all working together to accomplish the goals of the Medicaid program. Housed in a single building, the IME has contract staff who participates in the following activities: provider services, member services, provider audit and rate setting, processing payments and claims, medical services, pharmacy, program integrity, and revenue collections. All contracts are selected through a competitive request for proposal (RFP) process. Contract RFPs are issued every five years.

All contracted entities are assigned a contract manager, are assessed through their performance-based contracts, and are required to present their performance on contract standards at a monthly meeting to the Medicaid Policy Staff. Further, non-MCO contracted entities and Medicaid Policy staff are located at the same site, which limits the barriers of routine management and oversight. In addition, all contracted agencies are required to complete a comprehensive quarterly report on their performance to include programmatic and quality measures designed to measure the contract activities as well as trends identified within Medicaid programs and populations.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

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

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver

- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
AA-1a: Number and percent of quarterly contract management reports, from the Medical Services Contractor and MCO, submitted within ten business days of the end of the reporting period. Numerator = # of timely quarter contract reports Denominator = # of quarterly contract management reports

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contracted entity and MCO performance monitoring

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

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

Performance Measure:
AA-2a: Number and amount of compensation withholdings, for the Medical Services Contractor, annually applied for inaccurate level of care determinations. Measured by the monetary units withheld as compensation from contract payments.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contracted Entity performance monitoring

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

Data Aggregation and Analysis:

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

Performance Measure:
AA-3a: Number and percent of quarterly contract management reports, from the Provider Services Contractor, submitted within ten business days of the end of the reporting period. Numerator = # of timely quarterly contracts reports Denominator = # of quarterly contract management reports

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contracted Entity performance monitoring

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: 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:
AA-4a: Number and amount of compensation withholdings, for the Provider Services Contractor, annually applied for inaccurate provider enrollment functions. Measured by the monetary units withheld as compensation from contract payments.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contracted Entity performance monitoring

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
AA-5a: Number and percent of quarterly contract management reports, from the HCBS QA Contractor, submitted within ten business days of the end of the reporting period. Numerator = # of timely quarterly contract reports Denominator = # of quarterly contract management reports

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contracted Entity performance monitoring

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

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

Data Aggregation and Analysis:

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

Performance Measure:
AA-6a: Number and percent of monthly major incident reports, from the HCBS QA Contractor and MCO, submitted within ten business days of the end of the reporting period. Numerator = # of timely monthly contract reports on incidents Denominator = # of monthly major incident reports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contracted Entity and MCO performance monitoring

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

☑ **Other** Specify: Contracted Entity and MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
AA-7a: Number and amount of compensation withholdings, for the HCBS QA contractor and MCO, annually applied for inappropriate quality assurance activities. Measured by the monetary units withheld as compensation from contract payments.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contracted Entity performance monitoring

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **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.
Beyond the oversight provided by the policy staff collective, each operating agency within the Iowa Medicaid Enterprise is assigned state staff to serve as a contract manager. This position oversees the quality and timeliness of monthly scorecards and quarterly contract reports. Further, the Iowa Medicaid Enterprise holds a monthly manager meeting in which the account managers of each contracted unit presents the operational and performance issues discovered and remediated within the past month. This allows all state staff to collectively sustain transparent administrative oversight.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If the contract manager, or policy staff as a whole, discovers and documents a repeated deficiency in performance of the contracted unit, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of invoiced payment compensation.

General methods for problem correction include revisions to state contract terms based on lessons learned.

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

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

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

◉ **No**

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

Appendix B: Participant Access and Eligibility

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

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☑	**Disabled (Physical)**	0	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

Participants must be blind or disabled as determined by the receipt of Social Security Disability benefits or by a disability determination made through DHS. Disability determinations are made according to Supplemental Security Income (SSI) guidelines under Title XVI or the Social Security Act or the disability guidelines for the Medicaid Employed People with Disabilities coverage.

Applicants age 25 and over must be ineligible for SSI for either excess income and/or deeming of a spouse's income or resources. Participants age 21 and over who are currently receiving services from the HD Waiver and are SSI eligible may remain on the waiver through age 40. DHS has been working to phase out this SSI eligibility restriction by extending the age an additional 3 years each year, beginning 2012. As a result, participants have been allowed to remain on the waiver according to the following:

2012 - Age 37
2013 - Age 40
2014 - Age 43
2015 - Age 46
2016 - Age 49

For those participants that would lose their waiver services as a result of this restriction, the participant is assisted by the service worker, case manager, health home coordinator, or community-based case manager to locate other services through other HCBS waivers or State Plan services. DHS anticipates future Administrative Rulemaking to codify this phase-out process/exemption, with the stipulation the applicant/participant meets all other eligibility criteria for the HD Waiver.

Applicants under age 25 may be eligible for SSI or may be ineligible for SSI for either having excess income, deeming of a spouses or parents income/resources or a combination of both factors.

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

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

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

Specify:

Upon reaching the age of 65, participants may be eligible to receive services through another HCBS waiver (e.g., the Elderly waiver); however, they would need to apply for enrollment. The SSI eligibility restriction will be

phased out over a period of time as noted in subsection (b) above. For those participants that would lose their waiver services as a result of this restriction, the participant is assisted by the service worker, case manager, health home coordinator, or community-based case manager to locate other services through other HCBS waivers or State Plan services.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ( ) **Other**

    Specify:

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

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

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

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	

Waiver Year	Unduplicated Number of Participants
	3762
Year 2	4036
Year 3	3080
Year 4	3226
Year 5	3377

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

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	3386
Year 2	3633
Year 3	2800
Year 4	2800
Year 5	2800

Appendix B: Participant Access and Eligibility

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

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

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

○ **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

Select one:

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

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

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

Per Iowa Code 441-83.3(2)b, if no waiver slot is available, DHS enters applicants on the HD waiting list according to the following: "(1) [a]pplicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later[;] (2) [a]pplicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)"a"(2) is received by the department[;] (3) [i]n the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number[;] (4) [a]pplicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available[; and] (5) [o]nce a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot."

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**
2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (●) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**

- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ○ **100% of the Federal poverty level (FPL)**
- ○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

All other mandatory and optional categorically needy groups under the Medicaid State Plan are included.

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [x] **A special income level equal to:**

Select one:

- ◉ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

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

Specify dollar amount:

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

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
☐ **Aged and disabled individuals who have income at:**

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- ○ **The following standard included under the State plan**

  Select one:

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

    (*select one*):

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

      Specify the percentage:
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ○ **A percentage of the Federal poverty level**

    Specify percentage:
  - ○ **Other standard included under the State Plan**

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

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

  Specify:
- ◉ **Other**

  Specify:

  The following formula is used to determine the needs allowance: 300% of the SSI benefit and for participants who have a medical assistance income trust (Miller Trust) an additional $10 (or higher if court

ordered) to pay for administrative costs.

DHS determines patient liability. For managed care enrollees with a patient liability, DHS will communicate to the MCO the amount of each member's liability. Members will be responsible for remitting their patient liability to their waiver providers. The MCO reduces its payment for a member's waiver services up to the amount of the patient liability.

The capitation rates calculated for MCOs includes a long-term services and supports (LTSS) component which is a blend of institutional services and home and community based services (HCBS). When capitation rates were developed, the LTSS component was calculated with consideration given to patient liability as a possible source of funds used to pay a portion of the services provided through the waiver. For both the institutional and HCBS component of the rate, the average patient liability was subtracted. Therefore, the MCOs are paid net of the average patient liability.

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

- (●) **Not Applicable**
- ( ) **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

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

- ( ) **SSI standard**
- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

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

- ( ) **The amount is determined using the following formula:**

Specify:

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

- ( ) **Not Applicable (see instructions)**
- (●) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

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

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

Specify percentage:

○ **The following dollar amount:**

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

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

Specify formula:

◉ **Other**

Specify:

300% of the SSI benefit and for consumers who have a medical assitance income trust (Miller Trust) an additional $10 (or higher if court ordered) to pay for administrative costs.

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

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The State does not establish reasonable limits.**

○ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

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

Specify the entity:

◉ **Other**
Specify:

The IME MSU is responsible for determining the initial level of care evaluation for waiver enrollment with the input of the service worker, case manager, health home coordinator, community-based case manager, medical professional, and other appropriate professionals. For fee-for-service participants, the reevaluation is also conducted by the IME MSU. MCOs are responsible for reevaluations of their members. The IME MSU reviews and approves all reevaluations that indicate a change in the member's level of care. MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. Upon identification the MCO completes the initial level of care assessment with the IME MSU maintaining final review and approval authority.

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

Medical professionals (i.e., licensed physician, physician assistant or advanced registered nurse practitioner) perform the initial evaluation. The IME requires that individuals making level of care determinations be licensed registered nurses.

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

IME Medical Services uses the Form 470-4392, Level of Care Certification. Specifically, the tool assesses: (1) whether the individual requires supervision or limited assistance, provided on a daily basis by the physical assistance of at least one person, for dressing and personal hygiene activities of daily living (as defined by the minimum data set Section G, entitled Physical Functioning and Structural Problems); and (2) whether the individual requires the establishment of a safe, secure environment due to modified independence (some difficulty in new situations only) or moderate impairment (decisions poor, cues and supervision required; never or rarely made a decision; danger to self or others) of cognitive skills for daily decision-making. There is no scoring system; however, areas of review include: (1) cognitive, mood and behavior patterns; (2) physical functioning-mobility; (3) skin condition; (4) pulmonary status; (5) continence; (6) dressing and personal hygiene (ADLs); (7) nutrition; (8) medications; (9) communication; and (10) psycho-social.

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

○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

DHS Assessment and Services Evaluation (ASE) criteria are used to evaluate both waiver and institutional level of care. The Form 470-4392, Level of Care Certification used for waiver services identifies care needs in the home setting that are not the same for the institutional setting. The results of the assessment are used to develop the plan of care. Because the same criteria are used for both institutional care and waiver services, the outcome is reliable, valid and fully comparable.

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

An initial evaluation is initiated by a State income maintenance worker and participant/family member, or service worker, and sent to the participant/guardian. The participant/guardian is responsible for meeting with a medical professional (i.e., MD, PA, APN) to complete the level of care evaluation. The medical professional then completes the level of care evaluation and submits it via fax to the IME MSU. The IME MSU is responsible for determining the level of care based on the completed evaluation tool and supporting documentation from the medical professional.

The Continued Stay Review (CSR) is completed annually and uses the same assessment tool as is used with the initial level of care determination. It is the responsibility of the service worker, case manager, health home coordinator, or community-based case manager to assure the assessment is initiated as required to complete the CSR. For fee-for-service participants, the ISIS system sends out a milestone 60 days prior to the CSR date to remind service workers, case manager, and health home coordinators of the upcoming annual LOC process.

MCOs are responsible for conducting level of care reevaluations for members, using DHS designated tools, at least annually, and when the MCO becomes aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. Additionally, any member or provider can request a reevaluation at any time. Once the reevaluation is complete, the MCO submits the level of care or functional eligibility information via fax to the IME MSU. The State retains authority for determining Medicaid categorical, financial, level of care or needs-based eligibility and enrolling participants into a Medicaid eligibility category. MCOs track and report level of care and needs-based eligibility reevaluation data, including, but not limited to, reevaluation completion date.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

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

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

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

Reevaluations of fee-for-service participants are tracked in the DHS Individualized Services Information System (ISIS). A reminder is sent out to the service worker, case manager, or health home coordinator for the evaluation 60 days before the reevaluation is due. A CSR report is available through ISIS to track if reevaluations are overdue and is monitored by Medical Services, the Bureau of Long Term Care (BLTC), and IME. MCOs are responsible for recording timely completion of level of care reevaluations of members. One hundred percent (100%) of member level of care reevaluations must be completed within twelve (12) months of the previous evaluation. The LOC contractor reports monthly, quarterly and annually on the timeliness of the initial and annual reevaluations completed. DHS reserves the right to audit MCO application of level of care criteria to ensure accuracy and appropriateness.

Should MCO reevaluations not be completed in a timely manner, DHS may require corrective action(s) and implement intermediate sanctions in accordance with 42 CFR 438, Subpart I. The nature of the corrective action(s) will depend upon the nature, severity and duration of the deficiency and repeated nature of the non-compliance. The non-compliance corrective actions may be instituted in any sequence and include, but are not limited to, a written warning, formal corrective action plan, withholding of full or partial capitation payments, suspending auto-assignment, reassigning an MCO's membership and responsibilities, appointing temporary management of the MCO's plan, and contract termination. In the event of non-compliance with reevaluation timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3

years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All evaluation and reevaluation level of care documents are faxed to the IME MSU regardless of delivery system (i.e., FFS participants and MCO members) and placed in "OnBase." OnBase is the system that stores documents electronically and establishes workflow. In addition, the waiver participant's service worker, case manager, health home coordinator, or community-based case manager is responsible for service coordination for each participant. These providers maintain a working case file for each member and must maintain the records for a period of five years from the date of service. The case file includes all assessments, both initial and ongoing, completed during the time the participant was receiving waiver services. MCOs also maintain electronic case management systems that are used to capture and track all evaluations and reevaluations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
LC-1a: Number and percent of members that have a valid level of care assessment completed prior to receipt of waiver services. Numerator: # of valid level of care assessments made prior to service plan start dates Denominator: # of level of care assessments.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The data informing this performance measures is ISIS and MCO data. Reports are pulled and data is inductively analyzed at a 100% level. Conclusions are made based on the data that is pulled.

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

		☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
LC-1b: Number and percent of members who have a level of care determination completed within 12 months of their initial evaluation or last annual evaluation. Numerator: # of level of care assessments made within 12 months of previous assessment Denominator: # of level of care re-assessments due

Data Source (Select one):
Other
If 'Other' is selected, specify:
The data informing this performance measures is ISIS and MCO data. Reports are pulled and data is inductively analyzed at 100% level. Conclusions are made based on the data that is pulled.

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

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

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

Performance Measures

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

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

Performance Measure:
LC-1c: Number and percent of initial level of care determinations made for which criteria were accurately and appropriately applied for the determination. Numerator: # of accurate initial level of care determinations Denominator: # of initial level of care determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The Medical Services Unit performs internal quality reviews on the level of care determinations that have been made. Data is reported on a quarterly basis and conclusions reached inductively.

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 = 5%

☑ **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:
LC-2c: Number and percent of reevaluation of level of care determinations for which criteria were accurately and appropriately applied for the determination.
Numerator = # of accurate level of care determinations at reevaluation
Denominator = # of level of care determinations at reevaluation

Data Source (Select one):
Other
If 'Other' is selected, specify:
The Medical Services Unit performs internal quality reviews on the level of care determinations that have been made. Data is reported by IME and MCOs quarterly and conclusions reached inductively.

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 = 5%
☑ **Other** Specify: Contracted Entity and MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Data is collected quarterly through reports generated on ISIS and MCO data. Data is inductively analyzed at a 100% level. This data is monitored for trends in procedural standards from an individual and systems perspective.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The state's Individualized Services Information System (ISIS) is programmed to provide warnings when service plans are attempted to be entered prior to an initial or annual level of care determination. The programming was also intended to prevent service plans from being developed prior to the level of care determinations but it has been identified that there is a cushion of time in which the case manager may enter in service plan revisions/extensions beyond the level of care due date. Action is being taken to investigate and remediate this issue.
The state's Medical Services Unit performs internal quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred the unit recommends that the service worker take steps to initiate a new level of care determination through communication with the member and physician.

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: Contracted Entity including MCO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver

services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

In accordance with 42 CFR 441.301 and the Iowa Administrative Code 441-90.5(1)b and 441-83, service plans must reflect the services and supports that are important for the participant to meet the needs identified through the needs assessment, as well as what is important to the participant with regard to preferences for the delivery of such services and supports. The service plan, developed through a "person-centered" planning process, must reflect the participant's needs and preferences and how those needs will be met by a combination of covered services and available community supports.

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

During enrollment of fee-for-service participants, ISIS requires that service workers, case managers, and health home coordinators attest to having offered a choice between HCBS or institutional services. Choice is verified by : (1) marking the waiver box on the application; (2) sending a written request asking for waiver services; or (3) verbally confirming the participant's choice with the income maintenance worker and the worker documents the conversation. MCO community case managers are required ensure that members are offered choice according to their respective MCO processes and forms, which are reviewed and approved by DHS.

Further, there are waiver informational brochures available to share with participants and their parents/guardians. Brochures are available at each of the DHS county offices. Information is also available on the IME and MCO websites. The brochures include information on eligibility, service descriptions, and the application process. Once a participant begins the enrollment process and has a service worker, case manager, health home coordinator, or community-based case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a participant's plan of care.

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

Freedom of Choice forms for fee-for-service participants is documented in participant service plans and in ISIS. MCOs are responsible for maintaining records that fully disclose the extent of services provided to members for a minimum of seven years, and must furnish such information to duly authorized and identified agents or representatives of the state and federal governments.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Iowa DHS adopts the policy as set forth in Title VI of the Civil Rights Act prohibiting national origin discrimination as it affects people with limited English proficiency. DHS shall provide for communication with people with limited English proficiency, including current and prospective patients or clients, family members and participants to ensure them an equal opportunity to benefit from services. DHS has developed policies and procedures to ensure meaningful access for people with limited English proficiency. This includes procedures to:

- Identify the points of contact where language assistance is needed.
- Identify translation and interpretation resources, including their location and their availability.
- Arrange to have these resources available in timely manner.
- Determine the written materials and vital documents to be translated, based on the populations with limited English proficiency and ensure their transition.

- Determine effective means for notifying people with limited English proficiency of available translation services available at no cost.
- Train department staff on limited English proficiency requirements and ensure their ability to carry them out.
- Monitor the application of these policies on at least an annual basis to ensure ongoing meaningful access to services.

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

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

MCOs must conform to DHS policies regarding meaningful access to the waiver by limited English proficient persons, and to deliver culturally competent services in accordance with 42 CFR 438.206.

- MCOs must provide language services at no cost to limited English proficiency members, and all written materials shall be provided in English and Spanish, as well as any additional prevalent languages identified by the State or through an analysis of member enrollment (i.e., any language spoken by at least five percent (5%) of the general population in the MCO's service area).
- MCOs must provide oral interpretation services free of charge to each member (this applies to all non-English languages, and is not limited to prevalent languages), and MCOs must notify all members that oral interpretation and translated written information is available and how to access those services. Written materials must include taglines in prevalent languages regarding how to access materials in alternative languages.
- MCOs must ensure that service plans reflect cultural considerations of the member and that service plan development is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b).
- MCOs must operate member services helplines that are available to all callers, and an automated telephone menu options must be made available in English and Spanish.
- MCOs must maintain member websites and mobile applications available in English and Spanish that are accessible and functional via cell phone.

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day**		
Statutory Service	**Homemaker**		
Statutory Service	**Respite**		
Extended State Plan Service	**Home Health Aide**		
Extended State Plan Service	**Nursing**		
Supports for Participant Direction	**Financial Management Services**		
Supports for Participant Direction	**Independent Support Broker**		
Supports for Participant Direction	**Self-Directed Community Support and Employment**		
Other Service	**Consumer Directed Attendant Care - Skilled**		
Other Service	**Consumer-Directed Attendant Care - Unskilled**		

Service Type	Service		
Other Service	Counseling Service		
Other Service	Home and Vehicle Modification		
Other Service	Home Delivered Meals		
Other Service	Individual Directed Goods and Services		
Other Service	Interim Medical Monitoring and Treatment		
Other Service	Monthly capitation payments		
Other Service	Nutritional Counseling		
Other Service	Personal Emergency Response		
Other Service	Self-directed Personal Care		

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

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Adult day care services are furnished four or more hours per days on a regularly scheduled basis for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functions of the individual. Meals provided as part of these services shall not constitute a full nutritional day. Transportation between the individual's place of residence and the adult day care center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health 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.

Physical, occupational and/or speech/language therapies are not included as components of this service.

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

A unit of service is 15-minutes (up to 4 units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day) or an extended day (8.25 to 12 hours per day).

The individuals' plan of care will address how the member health care needs are being met. The Iowa Department of Human Services service worker will monitor the plan. Overlapping of services is avoided by the use of a service worker who manages all services and the entry into the ISIS system. The service worker is required to check to make sure that EPSDT is used whenever possible for children under the age of 21 before going to waiver services. Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day

Provider Category:
Agency

Provider Type:
Adult Day Care

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Adult Day service providers certified by the Department of Inspections and Appeals as being in compliance with the standards for adult day services programs at IAC 481—Chapter 70.

Other Standard *(specify)*:
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based service.

The adult day service agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

Verification of Provider Qualifications

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

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:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. Components of the service are directly related to the care of the member and include:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and dishes.

c. Meal preparation planning and preparing balanced meals.

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

A unit of service is 15 minutes. The member's plan of care will address how the member's health care needs are being met. Authorization of this service must be made after assuring that there is no duplication or overlapping of services. Services provided under IDEA or the Rehabilitation Act of 1973 are not available. The Iowa Department of Human Services' service worker will monitor the plan.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [x] **Legally Responsible Person**

☑ **Relative**
☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

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

Certificate *(specify):*
In accordance with IAC 441-Chapter 77: Home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate with the Medicare program (Title XVIII of the Social Security Act sections 1861(o)and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.
Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based service.

The home health agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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:
09 Caregiver Support	09011 respite, out-of-home

Category 2:	Sub-Category 2:
09 Caregiver Support	09012 respite, in-home

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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 is to enable the member to remain in the member's current living situation. Staff to member ratios shall be appropriate to the member's needs as determined by the member's interdisciplinary team. The interdisciplinary team shall determine if the member shall receive basic individual respite, specialized respite or group respite. Basic individual respite means respite provided on a staff-to-member ratio of one to one to members without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse; group respite is respite provided on a staff to member ratio of less than one to one; specialized respite means respite provide on a staff to member ratio of one to one to members with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

The state of Iowa allows respite services to be provided in variety of settings and by different provider types. All respite services identified in Appendix J fall within the definition of basic, specialized or group respite. For reporting purposes in Appendix J, the following provider types are listed as separate respite service:

• Home Health Agency (HHA) may provide basic, group, and specialized respite
• Residential Care Facility for persons with Intellectual Disabilities (RCF/ID) may provide basic, group or specialized respite
• Homecare and Non-Facility based providers may provide basic, group and specialized respite
• Hospital or Nursing Facility – skilled, may provide basic, group and specialized respite
• Organized Camping programs (residential weeklong camp, group summer day camp, teen camp, group specialized summer day camp) may provide basic, group and specialized respite
• Child Care Centers may provide basic, group and specialized respite
• Nursing Facility may provide basic, group or specialized respite
• Intermediate Care facilities for persons with Intellectual Disabilities (ICF/ID) may provide basic, group or specialized respite

The payment for respite is connected to the staff to member ratio. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when provided in a residential 24 hours camp program.

Overlapping of services is avoided by the use of a service worker who manages all services and the entry into the ISIS system. The service worker is required to check to make sure that EPSDT is used whenever possible for children under the age of 21 before going to waiver services. Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973. Respite may be provided in the home, camp setting, and nursing facility.

Federal Financial Participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services provided outside the member's home, such as a licensed facility, shall not be reimbursable if the living unit where the respite is provided is reserved for another person on a temporary leave of absence. Respite may be provided in facilities (RCF/ID, ICF/ID etc.). This language is in the Iowa Administrative Code for respite services and is included in the renewal application to avoid the duplication of payment between Medicaid and the facility. Facilities are paid for reserved bed days as part of the facility per diem payment rate. Facilities are paid for days when the member is out of the facility for hospitalization, home visits, vacations, etc. Waiver funds cannot be used to pay for a person to stay in the facility in a bed that is being paid for as a reserved bed day.
a. Staff-to-consumer ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
b. A unit of service is a 15 minute unit.
c. The service shall be identified in the member's individual comprehensive plan.
d. Respite services shall not be simultaneously reimbursed with other residential or respite services, Medicaid or HCBS HD nursing, or Medicaid or HCBS HD home health aide services.
e. 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 24 hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
f. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441-83.1(249A).
g. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
h. 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.

For self direction, 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. The amount,frequency, or duration of the self-directed respite service is the same as respite that is not self-directed.

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	Camps
Agency	Home Care Agencies
Agency	Residential care facilities
Agency	Child Care Facilities
Agency	Respite care providers certified under the Intellectual Disability or Brain Injury waivers.
Agency	Nursing facilities, intermediate care facilities for the intellectually disabled, and hospitals
Agency	Group living foster care facilities for children
Agency	Adult Day Care Providers
Agency	Home Health Agencies
Agency	Assisted Living Programs

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):*
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.
Certificate *(specify):*
In accordance with Iowa Administrative Code 441-77.30(5) Respite care providers.
77.30(5)a.(5) Camps certified by the American Camping Association.

The ACA-Accreditation Program:
• Educates camp owners and directors in the administration of key aspects of camp operation, program quality, and the health and safety of campers and staff.
• Establishes guidelines for needed policies, procedures, and practices for which the camp is responsible for ongoing implementation.
• Assists the public in selecting camps that meet industry-accepted and government recognized standards. ACA's Find a Camp database provides the public with many ways to find the ideal ACA-accredited camp.

Mandatory standards include requirements for staff screening, emergency exits, first aid,aquatic-certified personnel, storage and use of flammables and firearms, emergency transportation, obtaining appropriate health information, among others.
www.ACAcamps.org/accreditation
Other Standard *(specify):*
Respite providers shall meet the following conditions:
Providers shall maintain the following information that shall be updated at least annually:
-The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
-An emergency medical care release.
-Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.
-The consumer's medical issues, including allergies.
-The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:
-Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

-Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
-Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.
-Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 Agencies
Provider Qualifications

License *(specify):*

Certificate *(specify):*
In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that a Home Health Agency must meet in order to participate in Medicare.

Eligible Home care agencies are those that meet the conditions set forth in Iowa Administrative Code 441--77.33(4).
a. Certified as a home health agency under Medicare, or
b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number. (at this time, the IDPH is no longer contracting for homemaker services.)

Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Subject to background checks prior to direct service delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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:
Residential care facilities
Provider Qualifications
License *(specify):*
Residential care facilities licensed by the department of inspections and appeals under 481 IAC Chapter 57.
Certificate *(specify):*

Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Subject to background checks prior to direct service delivery.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Servicse, Iowa Medicaid Enterprise, Provider Services Unit
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 Facilities
Provider Qualifications
License *(specify):*
Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 109.
Certificate *(specify):*

Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Subject to background checks prior to direct service delivery.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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:
Respite care providers certified under the Intellectual Disability or Brain Injury waivers.
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Respite care providers certified under the Intellectual Disability or Brain Injury Waivers outlined in Iowa Administrative Code 441-77.37(15) and 77.39(14).
77.37(15) Respite care providers under the Intellectual Disability Waiver.
a. The following agencies may provide respite services:
(1) Home health agencies that are certified to participate in the Medicare program.
(2) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.
(3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
(4) 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 441—Chapter 109.
(5) Camps certified by the American Camping Association.
(6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).
(8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
(9) Assisted living programs certified by the department of inspections and appeals.

77.39(14) - Respite care providers under the Brain Injury Waiver
a. The following agencies may provide respite services:
(1) Respite providers certified under the HCBS intellectual disability waiver.
(2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).
(3) 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 441—Chapter 109.
(4) Camps certified by the American Camping Association.
(5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
(6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
(7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
(8) Home health agencies that are certified to participate in the Medicare program.
(9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).
(10) Assisted living programs certified by the department of inspections and appeals.
Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Subject to background checks prior to direct service delivery.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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:
Nursing facilities, intermediate care facilities for the intellectually disabled, and hospitals
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Nursing facilities, intermediate care facilities for the intellectually disabled, and hospitals enrolled as providers in the Iowa Medicaid program

Nursing facilities defined in IAC 441 Chapters 81 :
"Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

Intermediate care facilities for the intellectually disabled licensed by the department of inspection and appeal under 441 IAC Chapter 64. Iowa Code 135C defines intermediate care facility for persons with an intellectual disability as "an institution or distinct part of an institution with a primary purpose to provide health or rehabilitative services to three or more individuals, who primarily have an intellectual disability or a related condition and who are not related to the administrator or owner within the third degree of consanguinity, and which meets the requirements of this chapter and federal standards for intermediate care facilities for persons with an intellectual disability established pursuant to the federal Social Security Act, §1905(c)(d), as codified in 42 U.S.C. §1396d, which are contained in 42 C.F.R. pt. 483, subpt. D, §410 – 480.

Hospitals enrolled as providers in the Iowa Medicaid program as defined in IAC 441 77.3:
77.3(1) Qualifications. All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program,subject to the additional requirements of this rule.
Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Subject to background checks prior to direct service delivery.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 facilities for children
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 441—Chapter 109.
Certificate *(specify):*
Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Subject to background checks prior to direct service delivery.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 Providers
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Adult day care providers certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.
Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Subject to background checks prior to direct service delivery.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*
In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an home health agency must meet in order to participate in Medicare.
Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Subject to background checks prior to direct service delivery.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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):*
Assisted living programs certified by the department of inspections and appeals under 441 IAC Chapter 67.
Initial certification process for a nonaccredited program.
(1) Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation review approval, the department shall determine whether or not the proposed program meets applicable requirements.
(2) If, based upon the review of the complete application including all required supporting documents, the department determines the proposed program meets the requirements for certification; a provisional certification shall be issued to the program to begin operation and accept tenants.
(3) Within 180 calendar days following issuance of provisional certification, the department shall conduct a monitoring to determine the program's compliance with applicable requirements.
(4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B,231C,231D) shall be followed.
(5) The department shall make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.
(6) The department shall notify the program of a final certification decision within 10 working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.

(7) If the decision is to continue certification, the department shall issue a full two-year certification effective from the date of the original provisional certification.

Initial certification process for an accredited program.
(1) Within 20 working days of receiving all finalized documentation, including state fire marshal approval, the department shall determine and notify the accredited program whether or not the accredited program meets applicable requirements and whether or not certification will be issued.
(2) If the decision is to certify, a certification shall be issued for the term of the accreditation not to exceed three years, unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.
(3) If the decision is to deny certification, the department shall provide the applicant an opportunity for hearing in accordance with rule 481—67.13(17A,231B,231C,231D).
(4) Unless conditionally issued, suspended or revoked, certification for a program shall expire at the end of the time period specified on the certificate.

Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Subject to background checks prior to direct service delivery.

Verification of Provider Qualifications

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

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:
Extended State Plan Service

Service Title:
Home Health Aide

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:
Home health aide services are an extension of the State Plan and personal or direct care services provided to the member, which are not payable under Medicaid as set forth in Iowa Administrative Code rule 441-—78.9(249A). This references to the fact that all state plan services must be accessed before seeking payment through the waiver. The scope and nature of waiver home health services do not differ from home health aid services furnished under the State Plan. Services are defined in the same manner as provided in the approved State Plan. Skilled nursing care is not covered. The provider qualifications in the State Plan apply.

Components of the waiver home health service include, but are not limited to:
(1) Observation and reporting of physical or emotional needs.
(2) Helping a client with bath, shampoo, or oral hygiene.
(3) Helping a client with toileting.
(4) Helping a client in and out of bed and with ambulation.
(5) Helping a client reestablish activities of daily living.
(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.
(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.
(8) Accompaniment to medical services or transport to and from school.

In some cases, a nurse may provide home health services if the health of the member is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

Home health services are provided under the Medicaid State Plan services until the limitations have been reached. Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973.

Overlapping of services is avoided by the use of a service worker who manages all services and the entry into the ISIS system. The service worker is required to check to make sure that EPSDT is used whenever possible for children under the age of 21 before going to waiver services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services must be authorized in the service plan. The Iowa Department of Human Services, service worker will monitor the plan. Home health services cannot be provided outside the home with the exception of accompanying a child to and from school.
a. Services shall be included in the member's individual comprehensive plan.
b. A unit is one hour.
c. A maximum of 14 units are available per week.

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 Agencies

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Home Health Aide

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

Certificate *(specify):*
In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an home health agency must meet in order to participate in Medicare.
Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based service.

The home health agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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:
Extended State Plan Service
Service Title:
Nursing

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to members in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. Nursing services under the Medicaid State Plan must be exhausted first. Nursing Care Services differ only in duration of services from Medicaid State Plan. Nursing Care Services under the waiver do not need to show an attempt to have a predictable end.

Overlapping of services is avoided by the use of a service worker who manages all services and the entry into the ISIS system. The service worker is required to check to make sure that EPSDT is used whenever possible for children under the age of 21 before going to waiver services. Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Nursing services cannot exceed the maximum Medicare rate in effect. A unit of service is a visit. A maximum of ten units are available per week.

The individuals' plan of care will address how the member health care needs are being met. The Iowa Department of Human Services' service worker will monitor the plan. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services. Services provided under IDEA or the Rehabilitation Act of 1973 are not available.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 Agencies

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Nursing

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

Certificate *(specify):*

In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an Home Health Agency must meet in order to participate in Medicare.

Other Standard *(specify):*

Providers must be:

(1) At least 18 years of age.

(2) Qualified by training.

(3) Subject to background checks prior to direct service delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

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

by members. The Iowa Department of Human Services will designate the Financial Management Service entities as organized health care delivery system.

Responsibilities of the financial management service. The financial management service shall perform all of the following services:
(1) Receive Medicaid funds in an electronic transfer.
(2) Process and pay invoices for approved goods and services included in the individual budget.
(3) Enter the individual budget into the web-based tracking system chosen by the department and enter expenditures as they are paid.
(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
(5) Conduct criminal background checks on potential employees pursuant to IAC 441—Chapter 119.
(6) Verify for the member an employee's citizenship or alien status.
(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate
(8) Assist the member in completing required federal, state, and local tax and insurance forms.
(9) Establish and manage documents and files for the member and the member's employees.
(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
(13) Establish a customer services complaint reporting system.
(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
(15) Develop a business continuity plan in the case of emergencies and natural disasters.
(16) Provide to the department an annual independent audit of the financial management service.
(17) Assist in implementing the state's quality management strategy related to the financial management service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The FMS currently has an upper payment limit of $66.95 a month. The upper limit may change periodically with Department approved provider rate increases.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 Institution

Provider Category	Provider Type Title

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

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

Certificate *(specify):*

Other Standard *(specify):*
As defined in IAC 441 Chapter 77.30(13), 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).
b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.
c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.
d. The financial institution shall enroll as a Medicaid provider.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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:
Information and Assistance in Support of Participant Direction
Alternate Service Title (if any):
Independent Support Broker

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Independent Support Brokerage (ISB) 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 ISB 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 ISB 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:
The service is necessary for members who choose the self-direction option at a maximum of 30 hours a year. When a member first initiates the self-direction option, the Independant 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 form the state. There will be a maximum rate per hour limit.

Overlapping of services is avoided by the use of a service worker who manages all services and the entry into the ISIS system. The service worker is required to check to make sure that EPSDT is used whenever possible for children under the age of 21 before going to waiver services. Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973.

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: Supports for Participant Direction
Service Name: Independent Support Broker

Provider Category:
Individual

Provider Type:
Individual Support Broker

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications:
a. The broker must be at least 18 years of age.
b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.
c. The broker shall not provide any other paid service to the member.
d. The broker shall not work for an individual or entity that is providing services to the member.
e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
f. The broker must complete independent support brokerage training approved by the department.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management System Provider, Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:
Once initially trained, the Individual Support Broker is placed on an 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.

Verification of qualifications occurs 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:

Other Supports for Participant Direction

Alternate Service Title (if any):

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:**

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 payment for social skills development, career placement, vocational planning, and independent daily living activity skill development. The outcome of this service is to maintain integrated living in the community or to sustain competitive 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.

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

• Career counseling
• Career preparation skills development
• Cleaning skills development
• Cooking skills development
• Grooming skills development
• Job hunting and career placement
• Personal and home skills development
• Safety and emergency preparedness skills development
• Self-direction and self-advocacy skills development
• Social skills development training
• Supports to attend social activities

• Supports to maintain a job
• Time and money management
• Training on use of medical equipment
• Utilization of public transportation skills development
• 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. The HD waiver allows for the following five waiver services to be converted to create a CCO budget:
1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Basic individual respite care.
4. Home delivered meals.
5. Homemaker services.

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.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **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: Supports for Participant Direction
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)*:

Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements:
• A business providing community supports and employment shall:
(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and
(2)Have current liability and workers' compensation coverage as required by law.

• All personnel providing individual-directed community supports and employment shall:
(1) Be at least 18 years of age.
(2) Be able to communicate successfully with the member.
(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

•The provider of individual-directed community supports and employment shall:
(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
(2) Submit invoices and time sheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and time sheets are received after this 30-day period.

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, the independent support broker, and the financial management service

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:

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:**

Service Definition *(Scope)*:
Consumer Directed Attendant Care skilled activities may include helping the member with any of the following skilled services while under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. This service may be provided in the private residence or assisted living. Skilled CDAC is not skilled nursing care, but is care provided by a lay person who has been trained to provide the specific service needed by the member.

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 nurse is responsible for overseeing the care of the Medicaid member but is not the service provider. The cost of the supervision provided under state plan funding and is not provided under the waiver.

Covered skilled service activities:
(1) Tube feedings of members unable to eat solid foods.
(2) Assistance with intravenous therapy which is 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 bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, re-teaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, re-motivation, and behavior modification.
(8) Colostomy care.
(9) Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.
(10) Postsurgical nurse-delegated activities under the supervision of the registered nurse.
(11) Monitoring medication reactions requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, 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.

Skilled CDAC service is not a duplication of Home Health Agency (HHA) skilled nursing. Overlapping of services is avoided by the use of a service worker who manages all services and the entry into the ISIS system. The service worker is required to check to make sure that EPSDT is used whenever possible for children under the age of 21 before going to waiver services. Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit of service is a 15 - minute unit provided by an individual or an agency. The member's plan of care will address how the member's health care needs are being met. The Iowa Department of Human Services' service worker will monitor the plan. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services. Services provided under IDEA or the Rehabilitation Act of 1973 are not available.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Action Agencies
Individual	Any individual who contracts with the member
Agency	Assisted Living Program
Agency	Home Care Provider
Agency	Chore Provider
Agency	Supported Community Living Providers
Agency	Home Health Agency
Agency	Adult Day Services Provider

Appendix C: Participant Services

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

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

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

Certificate *(specify):*
Community Action Agencies as designated in Iowa Code 216A.93.
Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
(3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

The community agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

For skilled CDAC, the 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. 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 consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-

directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Departmtne of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 - Skilled

Provider Category:

Individual

Provider Type:

Any individual who contracts with the member

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

An individual who contracts with the member to provide attendant care service and who is:
1. At least 18 years of age, and
2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.
3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
5. All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has a founded abuse record.

For this service the department the specific standards for subcontracts or providers regarding training, age limitations, experience or education are indicated above. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 - Skilled

Provider Category:

Agency

Provider Type:
Assisted Living Program
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Assisted living programs that are certified by the Iowa department of inspections and appeals under 481—Chapter 69.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 - Skilled

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

Certificate *(specify):*
Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in Iowa Administrative Code 641-—80.3(5),—80.3(6), and 80.3(7).
Other Standard *(specify):*
Providers must be:
1. At least 18 years of age.
2. Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
3. Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

For skilled CDAC, the 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. 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 consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 - Skilled

Provider Category:

Agency

Provider Type:

Chore Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chore provides subcontracting with the Area Agencies on Aging or with letters of approval from the Area Agencies on Aging that the organization is qualified to provide chore services.

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Other Standard *(specify):*

Providers must be:
1. At least 18 years of age.
2. Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
3. Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

The agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring

basis within the parameters of the service plan, CDAC agreement, and provider standards.

For skilled CDAC, the 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. 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 consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 - Skilled

Provider Category:

Agency

Provider Type:

Supported Community Living Providers

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Providers certified by the Department's Home and Community Based Services Quality Oversight Unit to provide Supported Community Living under the Intellectual Disability or Brain Injury Waiver as described in IAC 441 Chapters 77.37 and 77.39.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 - Skilled

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

Certificate *(specify):*
In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 - Skilled

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

Certificate *(specify):*
Adult day service providers that are certified by the Department of Inspections and Appeals under 481—Chapter 70.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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:

Consumer-Directed Attendant Care - Unskilled

HCBS Taxonomy:

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

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

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

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

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. This service may be provided in the private residence or assisted living. This service is not a duplication of Home Health Aide or Homemaker services; and is monitored by the service worker manager as part of inclusion in the member's plan. The service activities may include helping the member with any of the following non-skilled 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.
4) Toilet assistance, including bowel, bladder, and catheter assistance.
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, includes shopping and laundry.
7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider.
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 member directed attendant care services.
10) Tasks such as financial management and scheduling that require cognitive or physical assistance.
11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
(12) 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 service is 15 minutes. The member's plan of care will address how the member's health care needs are being met. The service worker will monitor the plan.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **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
Agency	Home Health Agency
Agency	Adult Day Service Providers
Agency	Supported Community Living
Agency	Community Action Agency
Agency	Home Care Provider
Individual	Any individual who contracts with the member
Agency	Assisted Living Programs

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-Directed Attendant Care - Unskilled

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

Certificate *(specify)*:
Chore provider subcontracting with area agencies on aging with letters from the area agencies on aging stating that the organization is qualified to provide chore services.

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.
Other Standard *(specify)*:
Providers must be:
1. At least 18 years of age.
2. Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
3. Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

The chore agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The CDAC provider must enter into an agreement with the member receiving services, such that there

is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 - Unskilled

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In accordance with IAC 441-Chapter 77: home health agencies(HHA) are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.

Other Standard *(specify):*

Providers must be:
1. At least 18 years of age.
2. Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
3. Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

The home health agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The

member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 - Unskilled

Provider Category:

Agency

Provider Type:

Adult Day Service Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Adult Day service providers certified by the Department of Inspections and Appeals under IAC 481 - Chapter 70.

Other Standard *(specify):*

Providers must be:
1. At least 18 years of age.
2. Qualified by training or experience to carry out the member'splan of care pusuant to the department-approved case plan or indiviudual comprehensive plan.
3. Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based service.

The adult day service agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 - Unskilled

Provider Category:

Agency

Provider Type:

Supported Community Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers certified by the Department's Home and Community Based Services Quality Oversight Unit to provide Supported Community Living under the Intellectual Disability or Brain Injury Waiver as described in IAC 441 Chapters 77.37 and 77.39.

Other Standard *(specify):*

Providers must be:

1. At least 18 years of age.
2. Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
3. Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

The Supported Community Living(SCL) agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 - Unskilled

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

Certificate *(specify):*
Community action agencies as designated in Iowa Code section 216A.92 and 93.
Other Standard *(specify):*
Providers must be:
1. At least 18 years of age.
2. Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
3. Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives respite services.

The community action agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprises, Provider Services Unit
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 - Unskilled

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

Certificate *(specify):*
Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in Iowa Administrative Code 641-—80.3(5),—80.3(6), and 80.3(7).
Other Standard *(specify):*
Providers must be:
1. At least 18 years of age.
2. Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
3. Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

The home care agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 - Unskilled

Provider Category:
Individual
Provider Type:
Any individual who contracts with the member

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An individual who contracts with the member to provide attendant care service and who is:
1. At least 18 years of age, and
2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.
3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
5. All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has a founded abuse record.

For this service the department the specific standards for subcontracts or providers regarding training, age limitations, experience or education are indicated above. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 - Unskilled

Provider Category:

Agency

Provider Type:

Assisted Living Programs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Assisted living programs that are certified by the Department of Inspections and Appeals under IAC 481—Chapter 69.

Other Standard *(specify):*

Providers must be:
1. At least 18 years of age.
2. Qualified by training or experience to carry out the member’s plan of care pursuant to the department-approved case plan or individual comprehensive plan.
3. Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

The assisted living agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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:

Counseling Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

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

Service Definition *(Scope):*
Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441 - 24.1(225C)to facilitate home management and prevent institutionalization. Counseling services are non-psychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the service plan for the member.

The counseling services available under this waiver are an extension to the state plan services. The service worker will monitor the service plan. Authorization of this service must be made after assuring that there is not duplication or overlapping of state plan services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or if the number of persons who comprise the groups exceeds six, the actual number of persons who comprise the group.

The member's service plan will address how the member's health care needs are being met. The services must be authorized in the service plan. The case manager/service worker will monitor the plan. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services. Services provided under IDEA or the Rehabilitation Act of 1973 are not available.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Mental Health Service Providers
Agency	Licensed Hospice Agencies
Agency	Community Mental Health Centers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling Service

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

Certificate *(specify):*
Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.
Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Subject to background checks prior to direct service delivery.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling Service

Provider Category:
Agency
Provider Type:
Licensed Hospice Agencies
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 or which are certified to meet the standards under the Medicare program for hospice programs.
Certificate *(specify):*

Other Standard *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Subject to background checks prior to direct service delivery.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling Service

Provider Category:
Agency
Provider Type:
Community Mental Health Centers
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):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Subject to background checks prior to direct service delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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:
Home and Vehicle Modification

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.
a. 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, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle modifications are not furnished to adapt living arrangements that are owned or leased by providers of waiver services. Modifications may be made to privately owned rental properties. Home and vehicle repairs are also excluded. Purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle is not allowable.
b. 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.

All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes. Services shall be performed following prior department approval of the modification as specified in 441 - sub-rule 79.1(17) and a binding contract between the provider and the member. All contracts for home or vehicle modification shall be awarded through competitive bidding.

Home modifications will not be furnished to adapt living arrangements that are owned or leased by providers of waiver services including an assisted living facility.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit of service is the completion of needed modifications or adaptations. HVM within the HD waiver is limited to a $6,366.64 per year. The member's plan of care will address how the member's health care needs are being met. Services must be authorized in the service plan by the service worker.

When the member has reached the upper limit of $6,366.64 per year, the service worker may assist the member to seek out other funding streams that may be available to assist them such as grants or other volunteer agencies that my assist.

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	HVM Providers Enrolled under Other Waivers
Agency	Area Agencies on Aging
Agency	Community Business

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:
HVM Providers Enrolled under Other Waivers
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Providers enrolled to participate as HVM providers under the Health and Disability Waiver (formerly the Ill and Handicapped waiver) as described in IAC 441 Chapter 30:
a.Area agencies on aging as designated in 17—4.4(231).
b.Community action agencies as designated in Iowa Code section 216A.93.
c.Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
d.Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

Enrolled as HVM providers under the Physical Disability Waiver as described in IAC 441 41:
a.Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
b.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.

Enrolled to provide HVM services under the Elderly Waiver described in IAC 441 Chapter 33:
a. Area agencies on aging as designated in 17—4.4(231).
b. Community action agencies as designated in Iowa Code section 216A.93.
c. Providers eligible to participate as home and vehicle modification providers under the health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

Enrolled to provide HVM services under the Brain Injury Waiver as described in IAC 441 Chapter 39:

a.Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.
b.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:
Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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:
Area Agencies on Aging

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Area agencies on aging as designated according to department on aging rules IAC 17—4.4(231)

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements. The department may, in its discretion, designate one area agency on aging to serve more than one planning and service area.4.4(2)Designation requirements for units of general purpose local government. Whenever the department designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984 or designates an existing area agency on aging, the department shall give the right of first refusal to a unit of general purpose local government if:
a.The unit of general purpose local government can meet the requirements established to serve as an area agency on aging pursuant to state and federal law; and
b.The unit of general purpose local government's geographical boundaries and the geographical boundaries of the planning and service area are reasonably contiguous.

4.4(3)Qualifications to serve. Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following:
a.An established office of aging operating within a planning and service area;
b.Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit;
c.Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose;
d.Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which for designation purposes is under the supervision or direction of the

department and which can and will engage only in the planning or provision of a broad range of supportive services or nutrition services within such planning and service area; or
e.Any other entity authorized by the Older Americans Act.

4.4(8)Official designation. An entity shall be designated the area agency on aging upon the commission's acceptance of the department's proposed recommendation for designation, the commission's approval of the area agency on aging area plan, and execution of the associated contract between the department and the area agency on aging. Official designation of an area agency on aging shall not occur until final disposition of all appeals.

Verification of Provider Qualifications

Entity Responsible for Verification:
Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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:
Community Business
Provider Qualifications

License *(specify)*:
441 IAC 77.30(9)"d" - 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.
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals

Category 2:	Sub-Category 2:
14 Equipment, Technology, and Modifications	14032 supplies

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope)*:
Home delivered meals are meals prepared elsewhere and delivered to a waiver member's residence. Each meal shall ensure the member receives a minimum of one third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National of the National Research Council of the National Academy of Sciences. The meal may be a liquid supplement which meets the minimum one third standard.

When a restaurant provides the home delivered meal, the member is required to have nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and explain that constitutes the minimum one third daily dietary allowance.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A maximum of 14 meals is allowed per week. A unit of service is a meal. The members' plan of care will address how the member's health care needs are being met. Services must be authorized in the service plan. The service worker will monitor the plan.

Services will be monitored by the service worker/case worker through the service plan to avoid duplication with other services such as with homemaker and consumer-directed attendant care. While homemaker and CDAC may cover meal prep and clean up; home delivered meals covers the cost of food which is not covered under any other waiver service.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies
Agency	Nursing Facilities
Agency	Subcontractor with Area Agencies on Aging
Agency	Hospitals
Individual	Assisted Living Facilities

Provider Category	Provider Type Title
Agency	Area Agencies on Aging
Agency	Medical Equipment and Supply Dealers
Agency	Home Care Agencies
Agency	Community Action Agencies
Agency	Restaurants

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

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

Certificate *(specify):*
In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an home health agency must meet in order to participate in Medicare.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department Of Human Services Iowa Medicaid Enterprise, Provider Services Unit
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 Delivered Meals

Provider Category:
Agency
Provider Type:
Nursing Facilities
Provider Qualifications
License *(specify):*
Licensed pursuant to Iowa Code Chapter 135C and qualifying for Medicaid enrollment as described in IAC 441 Chapter 81.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 Delivered Meals

Provider Category:

Agency

Provider Type:

Subcontractor with Area Agencies on Aging

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the Area Agencies on Aging stating the organization is qualified to provide home-delivered meals services.

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements. The department may, in its discretion, designate one area agency on aging to serve more than one planning and service area.
4.4(2)Designation requirements for units of general purpose local government. Whenever the department designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984 or designates an existing area agency on aging, the department shall give the right of first refusal to a unit of general purpose local government if:
a. The unit of general purpose local government can meet the requirements established to serve as an area agency on aging
pursuant to state and federal law; and
b. The unit of general purpose local government's geographical boundaries and the geographical boundaries of the planning
and service area are reasonably contiguous.
4.4(3)Qualifications to serve. Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following:
a. An established office of aging operating within a planning and service area;
b. Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose
of serving as an area agency on aging by the chief elected official of such unit;
c. Any office or agency designated by the appropriate chief elected officials of any combination of units of general
purpose local government to act only on behalf of such combination for such purpose;
d. Any public or nonprofit private agency in a planning and service area, or any separate

organizational unit within such
agency, which for designation purposes is under the supervision or direction of the department and which can and will
engage only in the planning or provision of a broad range of supportive services or nutrition services within such
planning and service area; or
e. Any other entity authorized by the Older Americans Act.

4.4(8)Official designation. An entity shall be designated the area agency on aging upon the commission's acceptance of the department's proposed recommendation for designation, the commission's approval of the area agency on aging area plan, and execution of the associated contract between the department and the area agency on aging. Official designation of an area agency on aging shall not occur until final disposition of all appeals.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 Delivered Meals

Provider Category:

Agency

Provider Type:

Hospitals

Provider Qualifications

License *(specify):*

Enrolled as a Medicaid Provider as described in IAC 441 Chapter 77.3: All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 Delivered Meals

Provider Category:
Individual
Provider Type:
Assisted Living Facilities
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Assisted living programs that are certified by the Department of Inspections and Appeals under 481—Chapter 69.
Other Standard *(specify):*
For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education than what would be contained in IAC 481-chapter 69. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 Delivered Meals

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

Certificate *(specify):*

Other Standard *(specify):*
Area agencies on aging as designated according to department on aging rules IAC 17—4.4(231)

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements. The department may, in its discretion, designate one area agency on aging to serve more than one planning and service area.
4.4(2)Designation requirements for units of general purpose local government. Whenever the department designates a new area agency on aging after the date of enactment of the Older Americans

Act Amendments of 1984 or designates an existing area agency on aging, the department shall give the right of first refusal to a unit of general purpose local government if:

a. The unit of general purpose local government can meet the requirements established to serve as an area agency on aging pursuant to state and federal law; and

b. The unit of general purpose local government's geographical boundaries and the geographical boundaries of the planning and service area are reasonably contiguous.

4.4(3)Qualifications to serve. Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following:

a. An established office of aging operating within a planning and service area;

b. Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit;

c. Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose;

d. Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which for designation purposes is under the supervision or direction of the department and which can and will engage only in the planning or provision of a broad range of supportive services or nutrition services within such planning and service area; or

e. Any other entity authorized by the Older Americans Act.

4.4(8)Official designation. An entity shall be designated the area agency on aging upon the commission's acceptance of the department's proposed recommendation for designation, the commission's approval of the area agency on aging area plan, and execution of the associated contract between the department and the area agency on aging. Official designation of an area agency on aging shall not occur until final disposition of all appeals.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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 Delivered Meals

Provider Category:

Agency

Provider Type:

Medical Equipment and Supply Dealers

Provider Qualifications

License *(specify):*

Certificate *(specify)*:
Medical equipment and supply dealer certified to participate in the Medicaid program as defined by IAC 441 Chapter 77.10. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 Delivered Meals

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

Certificate *(specify)*:
Home care providers meeting the standards set forth in subrule 77.33(4):
a. Certified as a home health agency under Medicare, or
b. Authorized to provide similar services through a contract with the Iowa department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 Delivered Meals

Provider Category:
Agency
Provider Type:
Community Action Agencies
Provider Qualifications

License *(specify):*

Certificate *(specify):*
Community action agencies as designated in Iowa Code section 216A.93
Other Standard *(specify):*
216A.92 Division of community action agencies.
1. The division of community action agencies is established. The purpose of the division of community action agencies is to strengthen, supplement, and coordinate efforts to develop the full potential of each citizen by recognizing certain community action agencies and supporting certain community-based programs delivered by community action agencies.
2. The division shall do all of the following:
a. Provide financial assistance for community action agencies to implement community action programs, as permitted by the community service block grant and subject to the funding made available for the program.
b. Administer the community services block grant, the low-income energy assistance block grants, department of energy funds for weatherization, and other possible funding sources. If a political subdivision is the community action agency, the financial assistance shall be allocated to the political subdivision.
c. Implement accountability measures for its programs and require regular reporting on the measures by the community action agencies.
d. Issue an annual report to the governor and general assembly by July 1 of each year.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications

Entity Responsible for Verification:
Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 Delivered Meals

Provider Category:
Agency
Provider Type:
Restaurants
Provider Qualifications

License *(specify):*
Licensed and inspected under Iowa Code Chapter 137F:
137F.3 Authority to enforce.
1. The director shall regulate, license, and inspect food establishments and food processing plants and enforce this chapter pursuant to rules adopted by the department in accordance with chapter 17A. Municipal corporations shall not regulate, license, inspect, or collect license fees from food establishments and food processing plants, except as provided in this section.

137F.4 License required.
A person shall not operate a food establishment or food processing plant to provide goods or services to the general public, or open a food establishment to the general public, until the appropriate license has been obtained from the regulatory authority. Sale of products at wholesale to outlets not owned by a commissary owner requires a food processing plant license. A license shall expire one year from the

date of issue. A license is renewable. All licenses issued under this chapter that are not renewed by the licensee on or before the expiration date shall be subject to a penalty of ten percent per month of the license fee if the license is renewed at a later date.

137F.10 Regular inspections.
The appropriate regulatory authority shall provide for the inspection of each food establishment and food processing plant in this state in accordance with this chapter and with rules adopted pursuant to this chapter in accordance with chapter 17A. A regulatory authority may enter a food establishment or food processing plant at any reasonable hour to conduct an inspection. The manager or person in charge of the food establishment or food processing plant shall afford free access to every part of the premises and render all aid and assistance necessary to enable the regulatory authority to make a thorough and complete inspection. As part of the inspection process, the regulatory authority shall provide an explanation of the violation or violations cited and provide guidance as to actions for correction and elimination of the violation or violations.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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:
Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

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 will be applied to the individual budget amount.

The following goods an services may not be purchased using 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)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **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: Individual Directed Goods and Services

Provider Category:
Individual
Provider Type:
Individual or businesses
Provider Qualifications
License *(specify):*
An individual/business providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.
Certificate *(specify):*
Businesses providing goods and services must have current liability and workers' compensation coverage.
Other Standard *(specify):*
All personnel providing individual-directed goods and services shall:
1. Be at least 18 years of age.
2. Be able to communicate successfully with the member.
3. Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
4. Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
5. Not be the parent or stepparent of a minor child member or the spouse of a member.

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

Verification of Provider Qualifications
Entity Responsible for Verification:
The member, independent support broker, and the financial management service
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:
Interim Medical Monitoring and Treatment

HCBS Taxonomy:

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

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

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

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

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.
a. Service requirements. Interim medical monitoring and treatment services shall:
(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.
b. Interim medical monitoring and treatment services may include supervision to and from school, but not the cost of the transportation.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limitations.
(1) A maximum of 12 hours of service is available per day.
(2) Covered services do not include a complete nutritional regimen.
(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services, including EPSDT services, provided under the state plan.
(4) Interim medical monitoring and treatment services may be provided only in the member's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.
(5) The staff-to-member ratio shall not be greater than one to six.
d. A unit of service is 15 minutes.

Overlapping of services is avoided by the use of a service worker who manages all services and the entry into the ISIS system. The service worker is required to check to make sure that EPSDT is used whenever possible for children under the age of 21 before going to waiver services. Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 Agencies
Agency	Child Care Facilities
Agency	Supported Community Living Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interim Medical Monitoring and Treatment

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

Certificate *(specify)*:
In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.
Other Standard *(specify)*:
Providers must:
1) Be at least 18 years of age.
2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
3) Not be a usual caregiver of the member.
4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 Medical Monitoring and Treatment

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

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

Other Standard *(specify):*
Providers must:
1) Be at least 18 years of age.
2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
3) Not be a usual caregiver of the member.
4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 Medical Monitoring and Treatment

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

Certificate *(specify):*
Supported community living providers certified according to subrule 77.37(14) or 77.39(13).
Other Standard *(specify):*
Providers must:
1) Be at least 18 years of age.
2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
3) Not be a usual caregiver of the member.
4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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:

Monthly capitation payments

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope)*:

Monthly capitation payments

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	N/A

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Monthly capitation payments

Provider Category:
Individual
Provider Type:
N/A
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
N/A
Frequency of Verification:
N/A

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:
Nutritional Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	M040 nutrition consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. Standard medical management practices can diagnose the need for nutritional counseling, but may not

be equipped by either staff or training to provide the long term, high intensity service provided by a nutritional counselor. Nutritional counseling can be medically necessary for chronic disease management as well as when a member is experiencing problematic weight gain or loss. Members experiencing eating disorders or chemical dependencies, taking certain prescription drugs (IE treating depression or anxiety), and with dietary restrictions benefit from the additional education and experience available with a nutritional counselor.

Nutritional counseling service must be face to face contact and specified in the service plan based on recommendations from a licensed dietitian.

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

A unit of services is 15 minutes. The member's service plan will show if the member's health care needs are being met. The service must be authorized in the service plan and the service worker will monitor the plan.

Overlapping of services is avoided by the use of a service worker who manages all services and the entry into the ISIS system. The service worker is required to check to make sure that EPSDT is used whenever possible for children under the age of 21 before going to waiver services. Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 Action Agency
Agency	Nursing Facilities
Agency	Home Health Agencies
Individual	Licensed Dietitians
Agency	Hospitals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Counseling

Provider Category:
Agency

Provider Type:
Community Action Agency

Provider Qualifications

License *(specify)*:

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

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Counseling

Provider Category:
Agency
Provider Type:
Nursing Facilities
Provider Qualifications
License *(specify):*
Licensed pursuant to Iowa code chapter 135C and enrolled with Medicaid as described in IAC 441 Chapter 81
Certificate *(specify):*

Other Standard *(specify):*

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Counseling

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

Certificate *(specify):*
In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:
Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Counseling

Provider Category:
Individual
Provider Type:
Licensed Dietitians
Provider Qualifications
License *(specify):*
Independent licensed dietitians under IAC 645—Chapter 81.
Certificate *(specify):*

Other Standard *(specify):*

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Counseling

Provider Category:
Agency
Provider Type:
Hospitals
Provider Qualifications
License *(specify):*
Hospitals enrolled as Medicaid providers employing a dietitian licensed under 645—Chapter 81. The hospital must be an enrolled Medicaid provider as described in IAC 441 Chapter 77.3.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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 service worker will monitor the plan.

Overlapping of services is avoided by the use of a service worker who manages all services and the entry into the ISIS system. The service worker is required to check to make sure that EPSDT is used whenever possible for children under the age of 21 before going to waiver services. Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency Response System Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response

Provider Category:
Agency

Provider Type:
Emergency Response System Providers

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Agencies which meet the conditions of participation for Emergency Response System Providers as set forth in Iowa Administrative Code 77.33(2).

a. 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.
b. 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.
c. 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.
d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.
e. 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:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
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 Personal Care

HCBS Taxonomy:

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

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

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

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

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; activities of daily living and incidental activities of daily living that help the person remain in the home and in their community. 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 service worker who manages all services and the entry into the ISIS system. The service worker 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. Overlapping of services is avoided by the use of a service worker who manages all services and the entry into the ISIS system. The service worker is required to check to make sure that EPSDT is used whenever possible for children under the age of 21 before going to waiver services. Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **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 Personal Care

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 16 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 shall have all the necessary licenses required by federal, state and local laws and regulations. The member 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, the independent support broker, and the financial management service

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:

DHS Service Workers or case managers provide case management services to fee-for-service participants enrolled in the State's §1915(c) PD, HD, ID, and Aids Waivers. Targeted case managers or integrated health home coordinators provide case management services to those fee-for-service participants enrolled in the State's §1915(c) Elderly, Brain Injury, and Children's Mental Health Waivers. Services are reimbursed through an administrative function of DHS.

MCO community-based case managers provide case management services to all members receiving HCBS. MCOs ensure ease of access and responsiveness for each member to their community-based case manager during regular business hours and, at a minimum, the community-based case manager contacts members at least monthly, either in person or by phone, with an interval of at least fourteen calendar days between contacts.

All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned. MCOs are contractually required to ensure the delivery of services in a conflict free manner consistent with Balancing Incentive Program requirements. DHS approves and monitors all MCO policies and procedures to ensure compliance.

Appendix C: Participant Services

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

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

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

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

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

1. For purposes of this section and section 249A.30 unless the context otherwise requires:
a. “Consumer” means an individual approved by the department to receive services under a waiver.
b. “Provider” means an agency certified by the department to provide services under a waiver.
c. “Waiver” means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2. If a person is being considered by a provider for employment involving direct responsibility for a consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

As part of the provider’s self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the criminal background checks. The provider agency is responsible for completing the required waiver to perform the criminal background check and submitting to the Department of Public Safety who conducts the check. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of criminal background checks are available to the Department upon request. The IME will assure that criminal background checks have been completed through quality improvement activities on a random sampling of providers, focused onsite reviews and during the full on-site reviews conducted every 5 years.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. Screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. DHS also completes any evaluation needed for screenings returned with records or charges. MCOs are also required to ensure that all required screening is conducted for providers who are not employees of a provider agency or licensed/accredited by a board that conducts background checks (i.e., non-agency affiliated self-direction service providers). DHS retains final authority to determine if an employee may work in a particular program.

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):

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

1. For purposes of this section and section 249A.30 unless the context otherwise requires:
a. “Consumer” means an individual approved by the department to receive services under a waiver.
b. “Provider” means an agency certified by the department to provide services under a waiver.
c. “Waiver” means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2. If a person is being considered by a provider for employment involving direct responsibility for a consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

Individual Consumer Directed Attendant Care (CDAC) is the only service that allows individuals to be providers. All others services must be provided by agency providers. Individual CDAC providers have child and dependent adult abuse background checks completed by the IME Provider Services prior to enrollment as a Medicaid provider.

All employees that provide direct services under the Consumer Choices Option under this waiver are required to complete child and dependent adult abuse background checks prior to employment with a member. The Fiscal Management provider completes the child and dependent adult abuse background checks and the employee will not pay for any services to the member prior to the completion of the checks.

All child and dependent adult abuse checks are conducted by the DHS unit responsible for the intake, investigation, and finding of child and dependent adult abuse. The provider agency is responsible for completing the required abuse screening form and submitting it to DHS to conduct the screening. Providers are required to complete the child and dependent adult abuse background checks of all staff that provides direct services to waiver members prior to employment. Providers are required to have written policies and procedures for the screening of personnel for child and dependent adult abuse checks prior to employment. As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the child and dependent adult abuse checks. The data and other information developed by the provider in the

areas of discovery, remediation, and improvement of child and dependent adult abuse checks are available to the Department upon request. The Department will assure that the child and dependent adult abuse checks have been completed through the Department's quality improvement activities of random sampling of providers, focused onsite reviews, initial certification and periodic reviews and during the full on-site reviews conducted every 5 years.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. Screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. DHS also completes any evaluation needed for screenings returned with records or charges. MCOs are also required to ensure that all required screening is conducted for providers who are not employees of a provider agency or licensed/accredited by a board that conducts background checks (i.e., non-agency affiliated self-direction service providers). DHS retains final authority to determine if an employee may work in a particular program.

Appendix C: Participant Services

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

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).**

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.*

A participant's relative or legal guardian may provide services to a participant. Payments may be made to any relative who is not the parent of a minor child, a spouse, or a legal representative of the participant. Legal representative means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a participant or the parent or stepparent of a member aged 17 or younger. The relative or legal guardian may be an Individual CDAC provider, a participant under the CCO 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 service worker, case manager, health home coordinator, or community-based 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.

Whenever a legal representative acts as a provider of consumer-directed attendant care, the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the participant's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event. In many situations, the participant requests the guardian provide services, as the guardian knows the participant 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 participant's service plan that is authorized and monitored by the participant's service worker, case manager, health home coordinator, or community-based case manager.

Service workers, case managers, health home coordinators, and community-based case managers are responsible to monitor service plans and assure the services authorized in the participant's plan are received. In addition, information on paid claims of fee-for-service members is available in ISIS for review. The ISIS System compares the submitted claim to the services authorized in the service plan prior to payment. The claim will not be paid if there is a discrepancy between the amount billed and the rate of pay authorized in the plan. The state also completes post utilization audits on waiver providers verifying that services rendered match the service plan and claim process. This applies to individual CDAC providers and provider agencies. MCOs are required to adhere to all state policies, procedures and regulations regarding payment to legal guardians, as outlined in this section.

Per to 441 Iowa Administrative Code 79.9(7):

"a. Except as provided in paragraph 79.9(7)'b,' medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)'a,' medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013.

For purposes of this paragraph, "legal representative" means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger."

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

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

○ **Other policy.**

Specify:

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

Iowa Medicaid providers will be responsible for providing services to fee-for-service participants. The Iowa Medicaid Provider Services Department markets provider enrollment for Iowa Medicaid. Potential providers may access an application on line through the website or by calling the provider services' phone number. The IME Provider Services Unit must respond in writing within five working days once a provider enrollment application is received, and must either accept the enrollment application and approve the provider as a Medicaid provider or request more information. In addition, waiver quality assurance staff and waiver program managers, as well as county and State service workers, case mangers, health home coordinators, market to qualified providers to enroll in Medicaid.

MCOs are responsible for oversight of their provider networks. For the first two years of an MCO contract, the entity must give all 1915(c) HCBS waiver providers, which are currently enrolled as Iowa Medicaid providers, the opportunity to be part of its provider network. During this time period, the MCO may recommend disenrollment of providers not meeting defined performance measures. The State retains authority for development of the performance standards, and for review and approval of any disenrollment recommendations.

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 management) reports and MCO data are used to retrieve data on the number of enrollment applications that are verified and approved. Data is inductively analyzed at 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 including MCO	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
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 = # enrolled providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
OnBase (workflow management) and MCO reports are used to retrieve data on the number of enrollment applications that are verified and approved. Data is inductively analyzed at 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 including MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 and MCO reports are used to retrieve data associated with the number of reenrollment applications that are verified and approved. Data is inductively analyzed at 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 including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
OnBase and MCO 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** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Data Aggregation and Analysis:

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

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:

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 and MCOs are 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 or MCO 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: MCO	☐ **Annually**

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

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

◉ **No**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

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

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

For each HCBS waiver, the Agency will establish an average aggregate monthly spending limit per person for persons enrolled in the waiver. MCOs will be provided the average aggregate monthly limit for each waiver no later than 90 days before the start of each contract period. The limit for each contract period will be established based on the aggregate average spending utilized in the capitation rate development. MCOs are responsible for managing overall average spending per person for each waiver within the established limit.

The MCO shall continually monitor members' expenditures against the aggregate monthly cost cap, and work with members reaching their cap to identify non-waiver services that are available and appropriate to be provided in the event the cap is met to assist the member in remaining in the community and prevent or delay institutionalization. If the MCO determines a member's needs cannot be safely met in the community and within the aggregate monthly costs defined in the waiver in which the member is enrolled, the MCO shall determine if additional services may be available through the MCO's own Exception to Policy to allow the member to continue to reside safely in the community. In the event the MCO denies an Exception to Policy and determines the member can no longer have his or her needs safely met through the waiver, and the member refuses to transition to a more appropriate care setting, the MCO shall forward this information to the State for review and consideration.

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.

Information about the HCB Settings requirements is referenced Attachment #2 HCB Settings.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Service Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
   - ☐ **Registered nurse, licensed to practice in the State**
   - ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
   - ☐ **Licensed physician (M.D. or D.O)**
   - ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
   - ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

☑ **Social Worker**

Specify qualifications:

Social workers develop service plans for fee-for-service participants.

Qualifications include: graduation from an accredited four-year college or university; or the equivalent of four years of full-time technical work experience involving direct contact with people in overcoming their social, economic, psychological, or health problems; or an equivalent combination of education and experience substituting the equivalent of one year of full-time qualifying work experience for one year (thirty semester or equivalent hours) of the required education to a maximum substitution of four years.

In addition, social workers may be required to have the following specified experience in the following areas if they are specifically working with these populations:

- Developmental disabilities: a minimum of one-year full-time (or equivalent part-time) experience in delivering or coordinating services for persons with developmental disabilities (i.e., severe, chronic mental or physical impairments). Positions that meet the mental retardation background noted above will normally meet this selective area too. Experience in providing services and treatment to autistic children or persons with epilepsy or cerebral palsy will also qualify.
- Mental retardation: a minimum of one year of full-time (or equivalent part-time) experience in delivering or coordinating services for persons with significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior manifested during the developmental period.

MCO community-based case managers develop service plans for members receiving HCBS. MCOs community-based case managers are required to meet all of the qualifications, requirements, and be accredited as specified in 441 Iowa Administrative Code Chapter 24 regarding the accreditation of providers of services to persons with mental illness, mental retardation, and developmental disabilities.

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

MCOs are required to maintain compliance with 441 Iowa Administrative Code Chapters 24, 83, and 90 regarding the provision of care coordination in a conflict free manner that administratively separates the final approval of service plans and approval of funding amounts. MCOs must propose methodologies to administer the program in a conflict free manner. These methodologies must be reviewed and approved by DHS.

The State will monitor MCO service plan development and implementation to ensure that service plans are developed in the best interest of the participant. MCOs are required to develop quality assurance tools and protocols that include internal safeguards for service plan development in addition to the external monitoring by the State.

The planning process is person-centered, with the participant directing plan development with the help of the service worker, case manager, health home coordinator, or community-based case manager, his/her authorized representative, or any other individuals he/she would like included. The participant may invite anyone of his/her choosing (i.e., family members, authorized representatives, friends, etc.) to participate in the process. This includes allowing the participant to make decisions about service options and identification of personal goals. If none of these individuals are available for an participant, the State expects the service worker, case manager, health home coordinator, or community-based case manager, to solicit input from participant-approved individuals who are familiar with the participant's care needs and preferences.

The service plan will be specific to the participant's needs and goals that are identified using, at a minimum, the level of care assessment results. The participant or legal guardian and the guardian, advocate, caregiver, primary care physician or authorized representative must be consulted in the development of the service plan. The plan will include goals and objectives, service schedules, medication management strategies, barriers to progress, and detail of interventions. When service needs are identified, the participant must be given information about the available network providers so that an informed choice of providers can be made. The entire care planning process is to be documented in the case record. If the participant disagrees with the assessment and/or authorization of placement/services (including the amount and/or frequency of a service), the service worker, case manager, health home coordinator, or community-based case manager must provide the participant with a written notice of action that explains the participant's right to file an appeal. The service worker, case manager, health home coordinator, or community-based case manager, assists the participant with filing for an appeal.

DHS will continue to conduct service plan reviews and monitoring in accordance with the HCBS Quality Improvement Strategy.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Information related to waiver services and general waiver descriptions are initially made available following receipt of a waiver application. Service plans are then developed with the participant and an interdisciplinary team, regardless of delivery system. Teams often consist of the participant and, if appropriate, their representative; service worker, case manager, health home coordinator, or community-based case manager; service providers; and other supporting persons selected by the participant. During service plan development, the participant and/or their representative is strongly encouraged to engage in an informed choice of services, and is offered a choice of institutional or HCBS. Planning is timely, occurs when convenient for the participant, and is intended to reflect the participant's cultural considerations. If the participant chooses to self-direct services, an Independent Support Broker is provided to assist with budgeting and employer functions. The IME Member Services Unit remains available at all times, during normal business hours, to answer questions and offer support to all Medicaid beneficiaries. Further, the Member Services Unit distributes a quarterly newsletter in effort to continually educate waiver participants about services and supports that are available but may not have been identified during the service plan development process.

Fee-for-service participants are also asked to complete a Service Worker Comprehensive Assessment form prior to the initiation of services and yearly thereafter. This form is given to the participant to describe their restrictions and needs for service. This is separate from the level of care form completed by the physician. This form may be used to provide additional information regarding the level of care needs and assists the participant and service worker, case manager, or health home coordinator in determining appropriate services and amounts. The member and the service worker, case manager, or health home coordinator are required to sign the form. The IME MSU remains available to answer questions and offer support. Further, the MSU distributes a quarterly newsletter in effort to continually educate participants about services and supports that are available but may not have been identified during the service plan development process. The fee-for-service person-centered planning processes must:

- Include people chosen by the individual;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the participant's main point of contact;

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

MCOs are contractually required to provide supports and information that encourage members to direct, and be actively engaged in, the service plan development process, and to ensure that members have the authority to determine who is included in the process. Specifically, MCO person-centered planning processes must:

- Include people chosen by the individual;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and Record the alternative home and community-based settings that were considered by the member.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

For fee-for-service participants, service plans are developed by the participant; DHS service worker, case manager or health home coordinator; and an interdisciplinary team. Planning meetings are scheduled at times and locations convenient for the individual. The service plan must be completed prior to services being delivered and annually thereafter, or whenever there is a significant change in the person's situation or condition. The service worker, case manager, or health home coordinator receives the assessment and level of care determination from medical services. A summary of the assessment becomes part of the service plan. The service worker, case manager, or health home coordinator uses information gathered from the assessment and then works with the participant to identify individual and family strengths, needs, capacities, preferences and desired outcomes and health status and risk factors. This is used to identify the scope of services needed.

The service worker, case manager, or health home coordinator informs the participant of all available non-Medicaid

and Medicaid services including waiver services. There are waiver informational brochures available to share with participants and their parents/guardians. Brochures are available at each of the DHS county offices. Information is also available on the IME and MCO websites. The brochures include information on eligibility, service descriptions, and the application process. Once a participant begins the enrollment process and has a service worker, case manager, health home coordinator, or community-based case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a participant's plan of care.

The service worker, case manager, or health home coordinator will also discuss with the participant the self-direction option and give the participant the option of self-directing services available. The participant and the interdisciplinary team choose services and supports that meet the participant's needs and preferences, which become part of the service plan. Service plans must:

- Reflect that the setting in which the individual resides is chosen by the participant;
- Reflect the participant's strengths and preferences;
- Reflect the clinical and support needs as identified through the needs assessment;
- Include individually identified goals and desired outcomes which are observable and measurable;
- Include the interventions and supports needed to meet participant's goals and incremental action steps as appropriate;
- Reflect the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
- Include the identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
- Include a description of any restrictions on the participant's rights, including the need for the restriction and a plan to restore the rights (for this purpose, rights include maintenance of personal funds and self-administration of medications);
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Include a plan for emergencies;
- Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her;
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed to, with the informed consent of the participant in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the participant and other people involved in the plan;
- Indicate if the participant has elected to self-direct services and, as applicable, which services the participant elects to self-direct; and
- Prevent the provision of unnecessary or inappropriate services and supports.

The service worker, case manager, or health home coordinator will be responsible for coordination, monitoring and overseeing the implementation of the service plan including Medicaid and non-Medicaid services. If a participant chooses to self-direct, the participant, with the help of a service worker, case manager, or health home coordinator, identifies who will be providing Independent Support Broker Services.

For MCO members, service plans are developed by the MCO; however, members lead the process whenever possible, with representatives included in a participatory role as needed and/or defined by the member. A team is established to identify services based on the member's needs and desires, as well as availability and appropriateness of services. The team is also responsible for identifying an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or when the member's needs change. Service plans are completed prior to services being delivered, and are reevaluated at least annually, whenever there is a significant change in the member's situation or condition, or at a member's request.

In accordance with 42 CFR 441.301 and 441 Iowa Administrative Code Chapters 90.5(1)b and 83, MCOs must ensure the service plan reflects the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan must reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports. The service planning process must address the full array of medical and non-medical services and supports provided by the MCO and available in the community to ensure the maximum degree of integration and the best possible health outcomes and participant satisfaction. Services plans must:

- Reflect that the setting in which the individual resides is chosen by the participant;
- Reflect the participant's strengths and preferences;
- Reflect the clinical and support needs as identified through the needs assessment;
- Include individually identified goals and desired outcomes which are observable and measurable;
- Include the interventions and supports needed to meet participant's goals and incremental action steps as appropriate;
- Reflect the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
- Include the identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
- Include a description of any restrictions on the participant's rights, including the need for the restriction and a plan to restore the rights (for this purpose, rights include maintenance of personal funds and self-administration of medications);
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Include a plan for emergencies;
- Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her;
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed to, with the informed consent of the participant in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the participant and other people involved in the plan;
- Indicate if the participant has elected to self-direct services and, as applicable, which services the participant elects to self-direct; and
- Prevent the provision of unnecessary or inappropriate services and supports.

MCO members have appeal rights, including access to a State Fair Hearing after exhausting the MCO appeal process. Members can continue services while an appeal decision is pending, when the conditions of 42 CFR 438.420 are met. MCOs are contractually required to implement a comprehensive strategy to ensure a seamless transition of services during program implementation. Further, MCOs are required to develop and maintain, subject to DHS approval, a strategy and timeline within which all waiver members will receive an in-person visit from appropriate MCO staff and an updated needs assessment and service plan. Services may not be reduced, modified or terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. Changes to these must receive DHS prior approval.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

During the evaluation/reevaluation of level of care, risks are assessed for FFS participants by DHS, and for MCO members by their respective MCO, using the Level of Care Certification, 470-4392 form. A summary of the assessment becomes part of the service plan and any risks are addressed as part of the service plan development process. The comprehensive service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the participant's needs change. In addition, providers of applicable services shall provide for emergency backup staff. All service plans must include a plan for emergencies and identification of the supports available to the participant in an emergency.

Emergencies are those situations for which no approved individual program plan exists and which, if not addressed, may result in injury or harm to the participant or other persons or significant amounts of property damage. The service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. In addition providers of applicable services shall provide for emergency backup staff.

Emergency plans are developed on the following basis:

- Providers must provide for emergency, back-up staff in applicable services.
- Interdisciplinary teams must identify in the service plan, as appropriate for the individual participant health and safety issues based on information gathered prior to the team meeting, including a risk assessment. This information is incorporated into the service plan.
- The team identifies an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or the individual's needs change.

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

The IME has developed a computer program named the Individualized Services Information System (ISIS) to support HCBS programs. For fee-for-service participants, this system assists the Medicaid Agency and the service worker, case manager, and health home coordinator with tracking information, and monitoring and approving the service plan. Through ISIS, the service worker, case manager, or health home coordinator authorizes service and service payments on behalf of the participant. There are certain points in ISIS process that require contacting the designated DHS central office personnel. The service worker, case manager, and health home coordinator are responsible for the development the service plan and the service plan is authorized through ISIS, which is the Medicaid Agency. (Refer to appendix A and H for ISIS system processes.)

Appendix D: Participant-Centered Planning and Service Delivery

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

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

During the service plan development process, all available qualified providers are identified to the participant and their interdisciplinary team. Participants are encouraged to meet with the available providers before making a selection. Participants are not restricted to choosing providers within their community. Information about qualified and accessible providers is also available to participants through their service worker, case manager, health home coordinator, community-based case manager, IME website, and/or MCO website. If an MCO is unable to provide services to a particular member using contract providers, the MCO is required to adequately and timely cover these services for that member using non-contract providers, for as long as the MCO's provider network is unable to provide them.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

DHS has developed a computer program named the Individualized Services Information System (ISIS) to support HCBS programs. This system assists DHS with tracking information, monitoring, and approving service plans for fee-for-service participants. (Refer to appendix A and H for ISIS system processes.) On a monthly basis, the IME MSU conducts service plan reviews. The selection size for the waiver has a 95% confidence level. This info is reported to CMS as part of Iowa's performance measures.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

DHS service workers, Iowa Child Health Specialty Clinics, case managers, or health home coordinators maintain fee-for-service participant service plans. MCO community-based case managers maintain MCO member service plans.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

DHS is responsible for monitoring the implementation of the service plan and the health and welfare of fee-for-service participants, including:

- Monitoring service utilization.
- Making at least one contact per month with the consumer, the consumer's legal representative, the consumer's family, service providers, or another person, as necessary to develop or monitor the treatment plan.
- Make a face-to-face contact with the consumer at least once every three months.
- Participating in the development and approval of the service plan in coordination with the interdisciplinary team at least annually or as needs change. If services have not been meeting participant's needs the plan is changed to meet those needs. The effectiveness of the emergency backup plan is also addressed as the service plan is developed.

The participant is encouraged during the time of the service plan development to call the service worker, case manager, or health home coordinator, if there are any problems with either Medicaid or non-Medicaid services. The service worker will then follow up to solve any problems. Monitoring service utilization includes verifying that:

- The participant used the waiver service at least once a calendar quarter.
- The services were provided in accordance with the plan.
- The participant is receiving the level of service needed.

The ISIS system is also used to assist with tracking information, monitoring services, and assuring services were provided to fee-for-service participants. If the participant is not receiving services according to the plan or not receiving the services needed, the participant and other interdisciplinary team members and providers are contacted immediately. HCBS specialists monitor the health and welfare, service plan implementation, and service worker, case manager, or health home coordinator, involvement during the home and community quality assurance review process. Participants are asked about their choice of provider, whether or not the services are meeting their needs, whether staff and care coordinators are respecting their choice and dignity, if they are satisfied with their services and providers, or whether they feel safe where they receive services and live. HCBS specialists also review the effectiveness of emergency back-up and crisis plans. These components are monitored through quality oversight

reviews of providers, member satisfaction surveys, complaint investigation, and critical incident report follow-up. All providers are reviewed at least once over a five-year cycle and participants are surveyed at a 95% confidence level. Information about monitoring results are compiled by the HCBS Quality Assurance and Technical Assistance Unit on a quarterly basis. This information is used to make recommendations for improvements and training.

The IME MSU also conducts quality assurance reviews of participant service plans at a 95% confidence level. These reviews focus on the plan development, implementation, monitoring, and documentation that is completed by the service worker, case manager, or health home coordinator. All service plans reviewed are assessed for participant participation, whether the participant needs are accurately identified and addressed, the effectiveness of risk assessments and crisis plans, participant access to waiver and non-waiver services, as well as coordination across providers to best serve the participant's needs. Information about monitoring results are compiled by the IME MSU on a quarterly basis. This information is used to make recommendations for improvements and training.

MCOs are responsible for monitoring the implementation of the service plan, including access to waiver and non-waiver services, the quality of service delivery, and the health, safety and welfare of members. After the initiation of services identified in a member's service plan, MCOs monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan. At minimum, the care coordinator must contact members within five business days of scheduled initiation of services to confirm that services are being provided and that member's needs are being met. MCOs also identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively If problems are identified, MCOs complete a self-assessment to determine what additional supports, if any, could be made available to assist the member. MCOs must develop methods for prompt follow-up and remediation of identified problems; policies and procedures regarding required timeframes for follow-up and remediation must be submitted to DHS for review and approval. Finally, any changes to a member's risk are identified through an update to the member's risk agreement. MCOs must report on monitoring results to the State

In the event of non-compliance with service plan timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues. If the MCO fails to develop a plan of care for HCBS waiver enrollees within the timeframe mutually agreed upon between the MCO and the Agency in the course of Contract negotiations the MCO will be assessed a noncompliance fee of $315 per occurrence.

b. **Monitoring Safeguards.** *Select one:*

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
SP-1a: Number and percent of service plans reviewed which address the member's assessed health risks. Numerator = # of reviewed service plans addressing assessed health risks Denominator = # of reviewed service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP-2a: Number and percent of service plans reviewed which address the member's assessed safety risks. Numerator = # of reviewed service plans addressing assessed safety risks Denominator = # of reviewed service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP-3a: Number and percent of service plans reviewed which reflect the member's assessed personal goals. Numerator = # of reviewed service plans reflecting assessed personal goals Denominator = # of reviewed service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
SP-1b: Number and percent of service plans reviewed which include signature of member on the service plan. Numerator = # of reviewed service plans with member signuature Denominator = # of reviewed service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	**Frequency of data 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 = 5%
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP-2b: Number and percent of service plans reviewed which list all services received by the member. Numerator = # of reviewed service plans listing all services Denominator = # of reviewed service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP-3b: Number and percent of service plans reviewed which list all of the member's providers. Numerator = # of reviewed service plans listing all providers Denominator = # of reviewed service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
SP-4b: Number and percent of service plans reviewed in which all funding sources are listed. Numerator = # of reviewed service plans listing all funding sources Denominator = # of reviewed service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
SP-5b: Number and percent of service plans reviewed which list the amount of services to be received by the member. Numerator = # of reviewed service plans listing amounts of all services Denominator = # of reviewed service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP-6b: Number and percent of service plans reviewed with a plan for supports available to the member in the event of an emergency. Numerator = # of reviewed service plans listing all supports available in event of emergency Denominator = # of reviewed service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
SP-7b: Number and percent of service plans reviewed which indicate that the member was presented choice regarding CCO. Numerator = # of reviewed service plans indicaing choice regarding CCO Denominator = # of reviewed service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

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 = 5%

☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
SP-1c: Number and percent of service plans which are revised on or before waiver member's annual due date. Numerator = # of service plans revised prior to due date Denominator = # of service plans revisions due

Data Source (Select one):
Program logs
If 'Other' is selected, specify:
Reports are pulled from ISIS and MCO data to illustrate the number of service plans that were revised prior to the due date. 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: Medicaid contracted entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
SP-2c: Number and percent of service plans reviewed which were revised when warranted by a change in the member's needs. Numerator = # of reviewed service plans revised when warranted by change in need Denominator = # of reviewed service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

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

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

Performance Measures

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

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

Performance Measure:
SP-1d: Number and percent of member surveys reporting the receipt of all services identified in the plan. Numerator = # of survey respondents reporting receipt of all services in service plan Denominator = # of suvey respondents

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
The IPES survey is conducted at a 95% confidence level and responses recorded in a database. Data is pulled and inductively analyzed.

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 = 5%
☑ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

Contracted Entity including MCO		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP-2d: Number and percent of service plan reviewed reporting the receipt of all services identified in the plan. Numerator = # of reviewed service plans reporting receipt of all services Denominator = # of reviewed service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

SP-1e: Number and percent of members whose enrollment indicates that a choice was offered between waiver services and institutional care. Numerator = # of member enrollments indicating choice between waiver services and institutional care Denominator = # of member enrollments

Data Source (Select one):
Program logs
If 'Other' is selected, specify:
Data is pulled from ISIS and MCO reports to indicate that the milestone was affirmed by the case manager that choice was offered between waiver/institutional care. Data inducitvely analyzed.

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

Data Aggregation and Analysis:

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

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

Performance Measure:
SP-2e: Number and percent of experience/satisfaction survey respondents who indicate that they received a choice of waiver providers. Numerator = # of survey respondents indicating choice of provider Denominator = # of survey respondents

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
The IPES survey is conducted at a 95% confidence level and responses recorded in a database. Data is pulled and inductively analyzed.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP-3e: Number and percent of case manager attestations found in service plan that provider choice was offered to the member during service plan development. Numerator = # of reviewed service plans with case manager attestations indicating choice of provider was offered to the member Denominator = # of reviewed service plans

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **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 Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the service worker is notified of deficiency and expectations for remediation. Development of a mechanism to collect service worker remediation request response is in development.

The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the service worker.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Medical Services Unit utilized criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the services worker is notified of deficiency and expectations for remediation. Development of a mechanism to collect service worker remediation request response is in development.

The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the service worker.

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

ii. **Remediation Data Aggregation**

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

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

c. **Timelines**

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how

participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Iowa offers two self-direction services for participants regardless of delivery (FFS participants or MCO members)—the Consumer Choices Option (CCO) and Consumer Directed Attendant Care (CDAC) service.

Consumer Choices Option (CCO)

The CCO offers both employer and budget authority to the participant self-directing services. At the time of service plan development and/or at the participant's request, the participant has the option to convert the following services into an individualized self-direction budget based on services that are authorized in their service plan: (1) consumer directed attendant care (unskilled); (2) home and vehicle modification; (3) basic individual respite care; (4) home delivered meals; and (5) homemaker services.

CCO gives participants control over a targeted amount of waiver dollars. Under CCO a participant may convert specific waiver services that have been authorized in the participant's service plan to create an individual monthly budget. Participants that choose to use CCO will use the individual monthly budget to meet their assessed needs by directly hiring employees or purchase other goods and services. A participant may use the following three types of self-direction services to meet their assessed needs: (1) self-directed personal care services; (2) self-directed community supports and employment; and (3) individual-directed goods and services

If any of these options are elected, an Independent Support Broker (ISB) and Financial Management Service (FMS), by Sate administrative rule, must be involved. Two budgets will be developed as a result of the service plan development traditional services budget (includes traditional services for which the participant does not have budget or employer authority) and the individual budget (includes services and supports for which the participant does have budget and employer authority). Self-directed personal care services are services and/or goods that provide a range of assistance in the participant's home or community, as well as activities of daily living and incidental activities of daily living that help the person remain in their home and in their community. Self-directed Community Supports and Employment are services that support the participant in developing and maintaining life and community integration. Individual-directed goods and services are services, equipment or supplies not otherwise provided through the Medicaid State Plan that address an identified need in the service plan. The item or services would decrease the need for other Medicaid services, and/or promote inclusion in the community, and/or increase the participant's safety in the community or home.

Participants have authority over the individual authorized budget to perform the following tasks: (1) contract with entities to provide services and support; (2) determine the amount to be paid for services with the exception of the independent support broker and the financial management service whereas reimbursement rates are subject to the limits in 441 Iowa Administrative Code Chapter 79.1(2); (3) schedule the provision for services; (4) authorize payment for waiver goods and services identified in the individual budget; and (5) reallocate funds among services included in the budget. Individual monthly budget development includes the costs of the FMS, ISB, and any services and supports chosen by the participant as optional service components.

All participants choosing CCO will work with an ISB who will help them plan for their individual budget and services. The ISB works at the direction of the participant and assists the participant with their budget. For example, the ISB may help develop a monthly budget, recruit and interview potential employees, or assist with required paperwork. The ISB is required to attend an ISB training prior working with participants. The ISB cannot be the guardian, power of attorney, or a provider of service to the member, to avoid potential conflicts of interest. Per 441 Iowa Administrative Code 78.34(13)"k," the ISB "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."

Participants will also work with an FMS provider that will receive Medicaid funds on behalf of the participant. The FMS is a Medicaid provider, and receives an electronic funds transfer (EFT) on a monthly basis for the participant's monthly budget amount. The FMS is responsible for paying all employer taxes as required. Employees of the participant are required to submit timecards within thirty days of providing the service for payment. The participant's monthly budget includes a monthly per member, per month fee for the FMS provider, with the remainder designated for the purchase of goods and services for the participant. Per 441 Iowa Administrative Code 78.34(13)"l," the FMS "shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service."

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

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

Consumer Directed Attendant Care (CDAC)

The CDAC service began in Iowa in 1996 and was the first attempt by the State to offer self-directed services. CDAC is a self-directed service that offers the participant employer authority only. There are two CDAC services—skilled and unskilled. See Appendix C for service description and provider qualifications. All CDAC providers are enrolled Medicaid providers, and may be an individual employee or an agency. There are no FMS or ISB services to support the CDAC service, and the enrolled CDAC provider performs all billing through the Medicaid MMIS systems. The participant is responsible for completing the CDAC agreement with the CDAC provider. The CDAC agreement identifies the personal care services that will be performed. The participant is responsible for hiring, directing, and supervising the CDAC provider to assure their identified needs are being met. Participants are also responsible for singing CDAC timecards to allow payment for services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Self-direction training and outreach materials are available through the IME website and MCOs. Materials include information on the benefits, responsibilities, and liabilities of self-direction. A brochure about this option has been developed and includes information about the benefits, responsibilities, and liabilities. This brochure is available at all the local DHS offices, the DHS website, and has been distributed to other community agencies. The participant may also call IME Member Services and request to have the brochure mailed directly to them. All participants must sign an informed consent contract and a risk agreement that permits the participant to acknowledge and accept certain responsibilities for addressing risks.

The service worker, case manager, health home coordinator, or community-based case manager is required to discuss this option along with the benefits, responsibilities and liabilities at the time of the service plan development and/or any time the participant's needs change. This results in information about participant direction activities being reviewed, at least annually, with the participant. This option is intended to be very flexible; participants can choose this option at any time. Once given information about this option, the participant can immediately elect this option, or can elect to continue or start with traditional services initially and then change to self-direction at a later date.

MCOs must also provide ongoing participant or representative training upon request and/or if it is determined a member needs additional training. Training programs are designed to address the following: (i) understanding the role of participants and/or representatives in self-direction; (ii) selecting and terminating providers; (iii) being an employer and managing employees; (iv) conducting administrative tasks such as staff evaluations and approval of time sheets; (v) scheduling providers; and (vi) back-up planning. All MCO training and education materials are subject to review and approval by the State.

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

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

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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

The IME uses a quality assurance process to interview participants in order to determine whether or not the representative has been working in their best interest. The interviews are completed primarily by telephone and may be completed in-person if requested. The interviews are conducted as an ongoing QA activity and are used to ensure that participants' needs are met and that services are provided. QA interviews are completed monthly with a randomly selected representative sample of participants. The interview sample selection size assures a 95% confidence level in the results of the interviews.

In addition, the Independent Support Broker provides monitoring of health and safety. The participant's service worker, case manager, or health home coordinator is responsible to assess individual needs and monitor service delivery to assure that the participant's health and safety are being addressed. Service

workers, case managers, and health home coordinators routinely review how services are being provided and monitor services to assure the participant's needs are being met, including how the representative is performing.

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Self-Directed Community Support and Employment	☑	☑
Homemaker	☑	☑
Home Delivered Meals	☑	☑
Consumer Directed Attendant Care - Skilled	☑	☐
Respite	☑	☑
Independent Support Broker	☑	☑
Individual Directed Goods and Services	☑	☑
Home and Vehicle Modification	☑	☑
Consumer-Directed Attendant Care - Unskilled	☑	☑
Self-directed Personal Care	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. **Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

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

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

☐ **Governmental entities**
☑ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:
Financial Management Service

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

Provide the following information

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

Entities providing FMS must be cooperative, not-for-profit member owned and controlled, federally insured financial institution that is and charged by either the National Credit Union Administration or the Credit Union Division of the Iowa Department of Commerce. The FMS must successfully pass a readiness review of certification by DHS or a financial institution charted by the Office if the Comptroller of the Currency, a Bureau of the United States Department of the Treasury, is a member of the Federal Reserve; and/or is federally insured by the Federal Deposit Corporation. Further, the entity must be enrolled as a Medicaid provider. Once enrolled and approved 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.

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

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

FMS entities are paid a monthly fee for their services.

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

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

- ☑ **Assist participant in verifying support worker citizenship status**
- ☑ **Collect and process timesheets of support workers**
- ☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

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

Specify:

Additional functions/activities:

- ☑ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

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

IME provides oversight of the FMS entities and monitors their performance yearly. Oversight is conducted through an annual self-assessment, and an on-site review completed by DHS or by a designated IME unit. As noted above, FMS entities must also be enrolled as Medicaid providers. The MCOs are required to mirror this oversight process for their FMS entities and the IME reviews for compliance and monitors outcomes.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

The service worker, case manager, health home coordinator, or community-based case manager provides the waiver participant with information and assistance with choosing the CCO program or CDAC service as part of the person centered service planning process. The service worker, case manager, health home coordinator, or community-based case manager also assists the participant in locating an Individual Support Broker to assist with the planning and managing a monthly CCO budget and is responsible for monitoring the delivery of goods and services as identified in the service plan.

The CCO program conducts regular CCO webinars to provide service workers, case managers, health home coordinators, community-based case managers, and ISB's with information on understanding and implementing the CCO program. The webinars also identify self-direction issues that have been identified through quality assurance activities. All service workers, case managers, health home coordinators, and community-based case managers are welcome to attend the webinars, which are also recorded and made available for those unable to attend.

The CDAC service began in Iowa in 1996 and was the first attempt by the State to offer self-directed services. CDAC is a self-directed service that offers the participant employer authority only. There are two CDAC services—skilled and unskilled. See Appendix C for service description and provider qualifications. All CDAC providers are enrolled Medicaid providers, and may be an individual employee or an agency. There are no FMS or ISB services to support the CDAC service, and the enrolled CDAC provider performs all billing through the Medicaid MMIS systems. The participant is responsible for completing the CDAC agreement with the CDAC provider. The CDAC agreement identifies the personal care services that will be performed. The participant is responsible for hiring, directing, and supervising the CDAC provider to assure their identified needs are being met. Participants are also responsible for singing CDAC timecards to allow payment for services.

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Self-Directed Community Support and Employment	☑
Homemaker	☐
Home Delivered Meals	☐
Monthly capitation payments	☐
Consumer Directed Attendant Care - Skilled	☐
Respite	☑
Nursing	☐
Independent Support Broker	☑
Individual Directed Goods and Services	☐
Financial Management Services	☑
Adult Day	☐
Personal Emergency Response	☐
Nutritional Counseling	☐
Counseling Service	☐
Home and Vehicle Modification	☐
Consumer-Directed Attendant Care - Unskilled	☐
Self-directed Personal Care	☑
Interim Medical Monitoring and Treatment	☐
Home Health Aide	☐

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

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

Through a contract with the Iowa Medicaid Enterprise (IME) the HCBS Quality Assurance and Technical Assistance Unit provides support and assistance to service workers, case managers, health home coordinators, community-based case managers, members, providers, ISBs, and others needing information about HCBS waiver programs. This includes the self-direction program. The technical assistance provided includes developing and conducting regularly scheduled webinar trainings, developing and implementing required ISB training and answering questions from the field about the CCO program.

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

For fee-for-service enrollees, DHS service workers, case managers, or health home coordinators will terminate use of the self-direction option any time there is substantial evidence of Medicaid fraud or obvious misuse of funds. Involuntary termination can also occur if the service worker, case manager, or health home coordinator is not able to verify the types of services provided and the outcome of those services. If the participant and their representative are both found unable to self-direct, the participant will be transitioned to regular waiver services. The participant has the right to appeal any adverse action taken by the service worker, case manager, or health home coordinator to terminate self-directed services and is subject to the grievance and appeals protections outlined in Appendix F. The service worker, case manager, or health home coordinator will develop a new service plan and assure alternative services are in place to maintain service.

MCOs may only initiate involuntarily termination of a member's use of the self-direction option if there is evidence of Medicaid fraud or misuse of funds, or if the MCO determines there is a risk to the member's health or safety. Under these conditions, MCOs are required to submit a request to DHS for review and approval to involuntarily terminate. Requests must contain sufficient documentation regarding the rationale for termination. Upon DHS approval, MCOs must notify the member and facilitate a seamless transition to traditional waiver services to ensure there are no interruptions or gaps in service delivery.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		253
Year 2		303
Year 3		353
Year 4		403
Year 5		453

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

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

check. MCOs are responsible for the costs of investigations of workers who provide waiver services to members.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how

the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Under the traditional service model for the waiver, the participant chooses a service provider from a list of providers who are enrolled with Iowa Medicaid. The service worker, case manager, or health home coordinator and participant work together to detail the tasks and goals for the provider. After service provision, the provider submits a claim to the IME where the claim is adjudicated in accordance with IME protocols.

Under the self-direction option, a participant is not limited to the providers who have enrolled with Iowa Medicaid. The participant is considered the employer and can choose any individual that they feel is qualified to provide the needed service. Participants create support plans, make provider and service choices, select and employ staff, and monitor the quality of support services. MCOs are responsible for assisting the member with quality assurance activities and monitoring the quality of services provided. MCO plans to accomplish this contractual requirement are subject to DHS review and approval. Participants determine the wages to be paid to the provider and the units of service (limited by the self-direction budget). Interviewing, hiring, scheduling, and firing is done by the participant. Claims are submitted to the FMS for processing for payment.

Each participant who chooses to self-direct their services will continue to have a traditional service plan developed that is based on the level of care assessment and need of the participant. If a participant has a need for the services that can be included in the individual budget and they choose to self-direct one or all of those services, then the individual budget amount is determined by the amount of service that was authorized for those services under the traditional service plan. The level of need needed are determined by the level of care determination made by IME MSU; the supports needed and the amount of supports needed are determined through an assessment made by the service worker, case manager, or health home coordinator, prior to the participant selecting the self-direction option. Participants who reside in an assisted living facility may also choose to self-direct some of their services. Specifically, the participant can choose to self-direct services not provided by the facility (i.e., vehicle modification) or can choose another provider for services that are optional from the facility (i.e., meals or housekeeping).

Historically, participants do not use 100% of their authorized waiver services. To ensure that the State or MCO does not spend more than what is historically spent for traditional waiver services, each service authorized under self-direction will have a utilization adjustment factor applied to it. This utilization adjustment factor is determined by an analysis of what percentage of authorized services has historically been used for each service on an aggregate by all participants enrolled in that particular waiver who have accessed that particular service. The utilization factor is not based upon individual participant usage, but on historical percentage usage of authorized services by all participants enrolled in the waiver who have accessed that particular service. A participant new to the waiver or new to self-direction would have the same utilization factor applied as all other waiver participants who are self-directing services. The utilization adjustment factor will be analyzed, at a minimum, every 12 months and adjusted as needed based historical use. This method will be used for all waiver participants choosing the self-direction option. Participants are notified of the budget methodology and limits at the time they receive the CCO Booklet, during their service plan is development and by the Independent Support Broker hired to assist the individual to develop the budget. The individual budget methodology is stated in the 441 Iowa Administrative Code Chapter 78.41(15). In addition this information is shared during all outreach and training held throughout the State for participants, families, and other advocates. The MCOs are also responsible for making the budget methodology available to participants through their case managers and member communication materials.

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

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

If there is a need that goes beyond the budget amount and/or the waiver service limit, the participant has the

right to request an exception to policy. Exceptions to policy may be granted to the requestor when the participant has needs beyond the limits expressed in the Iowa Administrative Code. For fee-for-service enrollees this decision is made by the Director of DHS, based on an evaluation of the participant's needs in relation to the State's necessity to remain within the waiver's parameters of cost neutrality. The process to request an exception is shared on the DHS website as well as with the participant when they apply for waiver services. In addition, any participant has the right to appeal any decision made by DHS and to request an appeal hearing by an administrative law judge. The participant is afforded the opportunity to request a fair hearing when the budget adjustment is denied or the amount of budget is reduced as described in F-1.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Participants, regardless of delivery system (i.e., FFS participants and MCO members) will be informed of their budget amount during the development of the service plan. The participant can then make a final decision as to whether they want the self-direction option. If a participant needs an adjustment to the budget, the participant can request a review of the service plan. As noted above, if there is a need that goes beyond the budget amount and/or the waiver service limit, the participant has the right to request an exception to policy. In addition, any member has the right to appeal any decision. The participant is afforded the opportunity to request a fair hearing when the budget adjustment is denied or the amount of budget is reduced as described in F-1. MCO enrollees have the right to a State Fair Hearing after exhausting the MCO appeals process. It is the responsibility of the service worker, health home coordinator, case manager, and community case manager, to inform the participant of the budget amount allowed for services before the service plan is completed.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**

◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

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

For both fee-for-service and MCO participants, once the monthly budget amount has been established, the participant will develop a detailed monthly budget that identifies the goods and services that will be purchased and the employees that will be hired to meet the assessed needs of the member. This budget amount is the same amount whether the participant utilizes only traditional waiver services, utilizes only self-directed services, or uses a combination of traditional and self-directed services. All services under the waiver add into the one budget and that budget maximum is determined by the participant's level of care and not by the type of services accessed by the participant. Once the monthly budget amount has been

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Participants are given an oral explanation of the appeals (fair hearing) process during the application process by the income maintenance worker. The Department also gives participants an oral explanation at the time of any contemplated action. Depending on the adverse action, this could be done by the income maintenance worker, service worker, case manager, health home coordinator, community-based case manager, and/or medical provider performing the level of care determination. The participant is also given written notice of the following at the time of application, and at the time of any department actions affecting a claim for assistance, including choice of provider of service and denial, reduction, suspension or termination of service:

- The right to request a hearing.
- The procedure for requesting a hearing.
- The right to be represented by others at the hearing, unless otherwise specified by the statute or federal regulation.
- Provisions for payment of legal fees by DHS.
- How to have assistance including to right to continue services while the appeal is pending.

The choice of HCBS vs. institutional services is discussed with the participant at the time of the completion of the application by the income maintenance worker and again at the time of the service plan development by the service worker, case manager,

health home coordinator, or community-based case manager.

All DHS application forms, notices, pamphlets and brochures contain information on the appeals process and the opportunity to request an appeal. This information is available at all of the local offices and on the DHS website. The process for filing an appeal can be found on all Notices of Decision (NOD). Procedures regarding the appeal hearing can be found on the Notice of Hearing. As stated in Iowa Administrative Code, any person or group of persons may file an appeal with DHS concerning any decision, made. The participant is encouraged, but not required to make a written appeal on a standard Appeal and Request a Hearing form. Appeals may also be filed via the DHS website. If the participant is unwilling to complete the form, the participant would need to request the appeal in writing.

All notices are kept at all local DHS Offices or the service worker, case manager, health home coordinator, or community-based case manager's file. The participant is given their appeal rights in writing, which explains their right to continue with their current services while the appeal is under consideration. Copies of all notices for a change in service are maintained in the service file. IME reviews this information during case reviews.

MCOs give their members written notice of all actions, not only service authorization actions, in accordance with state and federal rules, regulations and policies, including but not limited to 42 CFR 438. MCO enrollment materials must contain all information on grievance and appeals rights as delineated in 42 CFR 438.10, including: (i) the right to file an appeal; (ii) requirements and timeframes for filing a grievance or appeal; (iii) the availability of assistance in the filing process; (iv) the toll-free numbers that the member can use to file a grievance or appeal by phone; (v) the fact that, if requested by the member and under certain circumstances, benefits will continue if the member files an appeal or requests a State fair hearing within the specified timeframe and that the member may be required to pay the cost of such services furnished during the appeal if the final decision is adverse to the member; and (vi) the right to a State hearing, including the method for obtaining a hearing and the rules that govern representation at the hearing.

MCOs must provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to providing interpreter services, and toll-free numbers that have adequate TTY/TTD and interpreter capability. Upon determination of the appeal, the MCO must ensure there is no delay in notification or mailing to the member and member representative the appeal decision. The MCO's appeal decision notice must describe the actions taken, the reasons for the action, the member's right to request a State fair hearing, process for filing a fair hearing and other information set forth in 42 CFR 438.408(e).

MCOs must maintain an expedited appeals process when the standard time for appeal could seriously jeopardize the member's health or ability to maintain or regain maximum function. The MCO must also provide general and targeted education to members and providers regarding expedited appeals including when an expedited appeal is appropriate and procedures for providing written certification thereof.

The MCO's appeal process must conform to the following requirements:

− Allow members, or providers acting on the member's behalf, thirty (30) calendar days from the date of action notice within which to file an appeal.
− In accordance with 42 CFR 438.406, ensure that oral requests seeking to appeal an action are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.
− The MCO must dispose of expedited appeals within three (3) business days after the Contractor receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c).
− In accordance with 42 CFR 438.410, if the MCO denies the request for an expedited resolution of a member's appeal, the MCO must transfer the appeal to the standard forty-five (45) calendar day timeframe and give the member written notice of the denial within two (2) business days of the expedited appeal request. The MCO must also make a reasonable attempt to give the member prompt oral notice.
− The MCO must acknowledge receipt of each standard appeal within three (3) business days.
− The MCO must make a decision on standard, non-expedited, appeals within forty-five (45) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 CFR 438.408(c). If the timeframe is extended, for any extension not requested by the member, the MCO must give the member written notice of the reason for the delay.
− In accordance with 42 CFR 438.408, written notice of appeal disposition must be provided with citation of the Iowa Code and/or Iowa Administrative Code sections supporting the action in non-authorization and care review letters that advise members of the right to appeal. For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice. The written notice of the resolution must include the results of the resolution and the date it was completed. For appeals not resolved wholly in favor of the member, the written notice must include the right to request a State

fair hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. The MCO shall direct the member to the Agency Appeal and Request for Hearing form as an option for submitting a request for an appeal. This shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds the Contractor's action.

Participants enrolled in an MCO must exhaust the entity's internal grievance processes before pursuing a State Fair Hearing. This requirement is outlined in the concurrent §1915(b) waiver, Part IV, Section E.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

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

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

Participants enrolled in an MCO must exhaust the entity's internal grievance and appeals processes before pursuing a State Fair Hearing. The policies and procedures regarding the MCO grievance and appeals system are outlined in the concurrent §1915(b) waiver, Part IV, Section E. MCO members can appeal any "action" within 30 days. An "action" is defined as the: (i) denial or limited authorization of a requested service, including the type or level of service; (ii) reduction, suspension or termination of a previously authorized service; (iii) denial, in whole or in part, of payment for a service; (iv) failure to provide services in a timely manner; or (v) failure of the MCO to act within the required timeframes set forth in 42 CFR 438.408(b). MCO members can also file grievances with their MCO; grievances are any written or verbal expression of dissatisfaction about any matter other than an "action." MCO members have the right to request a State Fair Hearing if dissatisfied with the outcome of the MCO appeals process. MCOs notify members of this right through enrollment materials and notices of action, including information that the MCO grievance and appeals process is not a substitute for a Fair Hearing.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

IME is responsible for operation of the complaint and grievance reporting process for all fee-for-service participants. In addition, the Department maintains an HCBS Quality Assurance and Technical Assistance Unit contract that is responsible for the handling of fee-for-service participant complaints and grievances in regards to provision of services under this waiver.

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

Any fee-for-service waiver participant, participant's relative/guardian, agency staff, concerned citizen or other public agency staff may report a complaint regarding the care, treatment, and services provided to a participant of services. A complaint may be submitted in writing, in person, by e-mail or by telephone. Verbal reports may require submission of a detailed written report. The complaint may be submitted to an HCBS Provider Quality Oversight Specialist, HCBS Program Manager, any IME Unit, or Bureau Chief of Long Term Care. Complaints by phone can be made to a regional HCBS Provider Quality Assurance Oversight Specialist at their local number or by calling the IME. The Bureau of Long Term Care has established a committee to review complaints. The committee will meet biweekly to review current complaints.

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

MCO members must exhaust the entity's internal grievance and appeals processes before pursuing a State Fair Hearing. The policies and procedures regarding the MCO grievance and appeals system are outlined in the concurrent §1915(b) waiver, Part IV, Section E. MCO members can appeal any "action" within 30 days. An "action" is defined as the: (i) denial or limited authorization of a requested service, including the type or level of service; (ii) reduction, suspension or termination of a previously authorized service; (iii) denial, in whole or in part, of payment for a service; (iv) failure to provide services in a timely manner; or (v) failure of the MCO to act within the required timeframes set forth in 42 CFR 438.408(b). In accordance with 42 CFR 438.406, oral requests seeking an appeal are treated by the MCO as an appeal; however, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.

MCO members have the right to request a State Fair Hearing if dissatisfied with the outcome of the MCO appeals process. MCOs notify members of this right through enrollment materials and notices of action. In accordance with 42 CFR 438.406, the MCO provides the member and their representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents or records considered during the appeals process. In addition, the member and their representative have the opportunity to present evidence and allegations of fact or law in person as well as in writing. Upon determination of the appeal, the MCO must promptly notify the member and his/her representative of the appeal decision. The MCO's appeal decision notice must describe the actions taken, the reasons for the action, the member's right to request a State Fair Hearing, process for filing a Fair Hearing and other information set forth in 42 CFR 438.408(e).

MCOs must ensure that the individuals rendering decisions on grievance and appeals were not involved in previous levels of review or decision-making and are health care professionals with appropriate clinical expertise in treating the member's condition or disease if the decision will be in regard to any of the following: (i) an appeal of a denial based on lack of medical necessity; (ii) a grievance regarding denial of expedited resolution of an appeal; or (iii) any grievance or appeal involving clinical issues. Appeals must be resolved by the MCO within 45 calendar days of receipt; this timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c).

MCOs must resolve appeals on an expedited basis when the standard time for appeal could seriously jeopardize the member's health or ability to maintain or regain maximum function. Such expedited appeals must be resolved within 3 business days after the MCO receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c). Standard appeals must be resolved within 45 calendar days; this timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c). If the timeframe is extended, for any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay. Within 90 calendar days of the date of notice from the MCO on the appeal decision, the member may request a State Fair Hearing.

MCO members can also file grievances with their MCO; grievances are any written or verbal expression of dissatisfaction about any matter other than an "action," as defined above. Grievances may be filed either orally or in writing; receipt is acknowledged by the MCO within 3 business days and resolved within 30 calendar days or as expeditiously as the member's health condition requires. This timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c).

MCOs are required to track all grievances and appeals in their information systems; this includes data on clinical reviews, appeals, grievances and complaints and their outcomes. MCOs are responsible for reporting on grievances

and appeals to DHS. This includes maintenance and reporting to the State the MCO member grievance and appeals logs which includes the current status of all grievances and appeals and processing timelines.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

All waiver service providers are required to document major and minor incidents and make the incident reports and related documentation available to DHS upon request. The provider must also ensure cooperation in providing pertinent information regarding incidents as requested by DHS.

Per Chapter 441 Iowa Administrative Code 77.25(1), “major incidents” are defined as an occurrence involving a participant during service provision that: (1) results in a physical injury to or by the participant that requires a physician’s treatment or admission to a hospital; (2) results in the death of any person; (3) requires emergency mental health treatment for the participant; (4) requires the intervention of law enforcement; (5) requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; (6) constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or (7) involves a participant’s location being unknown by provider staff who are assigned protective oversight. All major incidents must be reported within 48 hours of witnessing or discovering an incident has occurred, using the IME’s Iowa Medicaid Portal Access (IMPA) System. Suspected abuse or neglect may be reported to the statewide abuse reporting hotline operated by DHS.

Child and dependent adult abuse is an inclusive definition that includes physical and sexual abuse, neglect and exploitation. Child abuse is defined in Iowa Code 232.68, and may include any of the following types of acts of willful or negligent acts or omissions:

- Any non-accidental physical injury.
- Any mental injury to a child’s intellectual or psychological capacity.
- Commission of a sexual offense with or to a child.
- Failure on the part of a person responsible for the care of a child to provide adequate food, shelter, clothing or other care necessary for the child’s health and welfare.
- Presence of an illegal drug in a child’s body as a direct act or omission of the person responsible for the care of a child or manufacturing of a dangerous substance in the presence of a child.

Dependent adult abuse is defined in Iowa Code 235B.2, and may include any of the following types of acts of willful or negligent acts or omissions:

- Physical injury or unreasonable confinement, unreasonable punishment, or assault of a dependent adult.
- Commission of a sexual offense or sexual exploitation.
- Exploitation of a dependent adult.
- Deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care or other care

necessary to maintain a dependent adult's life or health.

When a major incident occurs, provider staff must notify the participant or the participant's legal guardian within 24 hours of the incident and distribute a complete incident report form as follows:

- Forward a copy to the supervisor with 24 hours of the incident.
- Send a copy of the report to the participant's service worker, case manager, health home coordinator, or community-based case manager (when applicable) and the BLTC within 24 hours of the incident.
- File a copy of the report in a centralized location and make a notation in the participant's file.

Per Chapter 441 Iowa Administrative Code 77.25(1), "minor incidents" are defined as an occurrence involving a participant during service provision that is not a major incident and that: (1) results in the application of basic first aid; (2) results in bruising; (3) results in seizure activity; (4) results in injury to self, to others, or to property; or (5) constitutes a prescription medication error. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the participant's file. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the participant's file.

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

MCOs are also required to develop and implement a critical incident management system in accordance with DHS requirements, in addition to maintaining policies and procedures that address and respond to incidents, remediate the incidents to the individual level, report incidents to the appropriate entities per required timeframes, and track and analyze incidents.

MCOs must utilize system information to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. All MCO staff and network providers are required to:

- Report critical incidents.
- Respond to critical incidents.
- Document critical incidents.
- Cooperate with any investigation conducted by the HCBS Quality Assurance and Technical Assistance Unit staff, MCO, or outside agency.
- Receive and provide training on critical incident policies and procedures.
- Be subject to corrective action as needed to ensure provider compliance with critical incident requirements.

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

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

Information concerning protections is provided to participants at the time of application and at the time of service plan development. During enrollment, and when any updates are made, DHS also provides to participants a Medicaid Members Handbook, which contains information regarding filing a complaint or grievance. MCO written member

enrollment materials also contain information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect. In addition, information can also be found on DHS and MCO websites. The DHS website contains a "Report Abuse and Fraud" section, which describes how to report dependent adult child abuse. The same information is also available in written format in all local DHS offices, and participants may also call the IME Member Services call center with any questions regarding filing a complaint or grievance. Finally, the service worker, case manager, health home coordinator, or case manager is responsible for assessing a participant's risk factors annually during the reevaluation process, as well as during the quality assurance interview process and the annual IPES interview. DHS recognizes the need to provide training to participants using on a more formal process. The state has developed training to ensure that service workers, case managers, health home coordinators, and community-based case managers provide this information to members at a minimum on a yearly basis.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

DHS Protective Services (PS) receives reports of child and dependent adult abuse and, if an immediate threat of physical safety is believed to exist, makes every effort to examine that child or dependent adult within one hour of receipt and/or take any lawful action necessary. If the child or dependent adult is not in danger, PS makes every effort to examine the child or dependent adult within 24 hours. PS notifies the participant's service worker, case manager, health home coordinator, or community-based case manager when an investigation has been initiated to ensure they are aware of the alleged abuse and to ensure that additional services can be added, or that changes can be made, to the participant's plan of care if needed. PS provides an evaluation report within twenty days of receipt of the report, which include necessary actions, and/or an assessment of services needed. The Central Registry of Abuse and County Attorney also receives PS reports. For both child and dependent adult abuse cases, the participant and/or the family are notified of the results in writing by DHS as soon as the investigation has concluded.

If the incident is a situation that has caused, or is likely to cause a serious injury, impairment, or abuse to the participant, and if PS has completed, or is in the process of conducting, an investigation, the HCBS specialist coordinates activities with PS to ensure the safety of the participant is addressed. If PS is not investigating, and immediate jeopardy remains, the participant's service worker, case manager, health home coordinator, or community-based case manager is notified immediately to coordinate services and the HCBS Specialist initiates a review within two working days of receipt of the report. If it is determined that immediate jeopardy has been removed or not present, review by the HCBS Specialist is initiated within twenty working days of receipt of report. The HCBS Specialist prepares a report of his/her findings within thirty days of the investigation being completed and presents it to the BLTC, the provider, and interested stakeholders (i.e., participants, guardians, etc.).

The BLTC meets biweekly to review critical incident reports of child and dependent adult abuse and participant deaths that have been reported through the critical incident reporting process. DHS reviews, and if needed, requests information for follow through and resolution of the abuse allegation and participant deaths from the service worker, case managers, health home coordinator, community-based case manager, or HCBS Specialist. Requests for information are forwarded to the service worker, case manager, health home coordinator, community-based case manager to verify any needed changes and confirm that follow-up has occurred with the participant (i.e., changes to a plan of care or the safety or risk plan as necessary). If additional information or actions are required of a provider, the HCBS Specialist works directly with the provider to ensure that performance issues identified in the incident report are addressed. The HCBS Specialist uses the provider's Self-Assessment as the foundation of the review to assure that accuracy in the Self-Assessment and to identify any corrective actions that may be required. The HCBS Specialist generates a report of findings within thirty days of the completion of any review requiring corrective actions.

Information requests to the service worker, case manager, health home coordinator, community-based case manager, or HCBS Specialist for follow up are tracked by the HCBS Unit on a weekly basis until the situation has been resolved. DHS implemented a web-based critical incident reporting system September 1, 2009, that significantly enhanced the State's ability to track and trend the discovery, remediation, and improvement of the critical incident reporting process. Revisions have been made to the system based on data collection and feedback from users, further enhancing the process. Incidents are reviewed by the HCBS Quality Oversight Unit within one business day of report and forwarded to the service worker, case managers, health home coordinator, community-based case manager as needed to coordinate any follow-up and communication with the participant, provider, and/or family/legal guardian. Incidents that lead to targeted review will initiate investigation by the HCBS Quality Oversight Unit within one business day. Findings reports are submitted to the Quality Assurance Manager within 15 days of investigation

completion. Once the finding report is approved by the Quality Assurance Manager, the findings report is sent to the provider and service worker, case manager, health home coordinator, community-based case manager or HCBS Specialist.

MCOs are responsible for developing and implementing critical incident management systems in accordance with the DHS requirements. Specifically, MCOs must maintain policies and procedures, subject to DHS review and approval, that: (1) address and respond to incidents; (2) report incidents to the appropriate entities per required timeframes; and (3) track and analyze incidents. This information is utilized to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. Training must be provided to all internal staff and network providers regarding the appropriate procedures for reporting, responding to, and documenting critical incidents. Network providers must provide training to direct care staff regarding the appropriate procedures for reporting, responding to, and documenting critical incidents.

Finally, MCOs are responsible for identifying and tracking all critical incidents and must review and analyze critical incidents to identify and address quality of care and/or health and safety issues. Such review should include a regular assessment of number and types of incidents and findings from investigations, and should be used to identify trends, patterns and areas for improvement. Based on these findings, the MCOs must develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DHS has oversight for monitoring incidents that affect all waiver participants. An HCBS Quality Assurance and Technical Assistance Unit reviews all critical incident reports as soon as they are reported to DHS. All critical incidents are tracked in a critical incident database that tracks the date of the event, the specific waiver the participant is enrolled in, the provider (if applicable), and the nature of the event, and follow up provided. If the incident has caused or is likely to cause a serious injury, impairment, or abuse to the participant, and if PS has completed or is in the process of conducting an investigation, the HCBS Specialist will coordinate with PS. If PS is not investigating, the HCBS Specialist will begin an on-site review within two working days of receipt of the report. If it is determined that the participant has been removed from immediate jeopardy, the review is initiated with in twenty working days of receipt of report. For other non-jeopardy incidents, a review is initiated within twenty days. The HCBS Quality Assurance and Technical Assistance Unit meets biweekly to review data tracked in the critical incident database and to decide if policy changes or additional training are needed. Data is compiled and analyzed in attempt to prevent future incidents through identification of system and provider specific training needs, and individual service plan revisions.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DHS policy regarding restraints is as follows, and applies to all types of restraints that may be used by waiver providers. The policy described in this section applies regardless of delivery system (i.e., FFS participants or MCO members), and MCOs are contractually obligated to adhere. Restraints include, but are not limited to, personal, chemical, and mechanical methods used for the purpose of controlling the free movement of an individual's body. Chemical restraints are most commonly used to calm an individual down in moments of escalation. Other examples of restraints include, but are not limited to, holding a person down with one's hands, tying an individual to a bed, using a straight jacket or demobilizing wrap. As a rights limitation, the restraint procedures must be agreed to by the interdisciplinary team and identified in the participant's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of restraints must be documented in a participant's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

- The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
- Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
- Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
- Restraint, restriction, and behavioral intervention programs shall be time-limited (maximum one year) and shall be reviewed at least quarterly.
- Corporal punishment and verbal or physical abuse are prohibited."

These safeguards are the same regardless of what restraints are used. All restraints must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All participants served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Restraint procedures may be designed and implemented only for the benefit of the person and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

Physical and chemical restraints may be allowed depending on the provider's agency policy to ensure that there is an accompanying behavioral intervention plan, documentation of each instance, and monitoring of its use. These types of restraints must be considered on an individual basis after the interdisciplinary team reviews them, and entered into the written plan of care with specific time lines. If a participant were placed in a closed room the time frame would need to be determined on an individual basis and spelled out in the service plan. The provider would need to document the use of this restraint in the participant's service file each time it was utilized by staff. The provider would be required to have a written policy approved by DHS on the supervision and monitoring of participants placed in a closed room such as monitoring on a fifteen minute basis for example to assure the health and welfare of the participant.

Restraint procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the individual's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:

- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of restraints and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Restraints and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.

- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. Staff must be trained and exhibit proficiency as described below before administering restraints. A person's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (i) the supervisor's ability to implement the procedure has been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Restraints and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a person's right to be free from aversive, intrusive procedures is balanced against the person's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter an individual's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the individual's service plan and the service worker, case manager, health home coordinator, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements.

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the person's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the individual and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:

- A Restraint and Behavioral Intervention Program that is a part of the written individual service plan developed by the participant's service worker, case manager, health home coordinator, or community-based case manager, and in the provider plan of care developed for the individual.
- Approval by the individual's interdisciplinary team, with the written consent of the person's parent if the person is under eighteen years of age, or the person's legal guardian, if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the person's health.
- A functional analysis that is defined as and includes the following components: (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior; (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors; (iii) description of the conditions that precede the behavior in question; (iv) description of what appears to reinforce and maintain the behavior; and (v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the individual, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Restraints must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All restraints are explained to the individual and their legal representative and agreed upon ahead of time.

Unauthorized use of restraints would be detected via interviews with the participant, their family and staff and services worker, health home coordinator, or community-based case manager; through review of critical incident reports by DHS and participant's services worker, health home coordinator, or community-based case manager on a daily basis; DHS and services worker, health home coordinator, or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints). Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the DHS policy for each type of agency identified restraint is observed and participant rights are safeguarded. If it is found that a waiver provider is not observing DHS policy or ensuring a participant's rights, adverse action is taken by the IME, which may include sanction, termination, required corrective action, etc.

The participant's service worker, case manager, health home coordinator, or community-based case manager, is responsible to monitor individual plans of care including the use of restraints and behavioral interventions.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The first line of responsibility for overseeing the use of restraints and ensuring safeguards are in place is the participant's service worker, case manager, health home coordinator, or community based case manager. The use of restraints must be assessed as needed and identified in the individual participant's service plan. The use of restraints would also require the development and implementation of a behavior plan and the plan would be included in the participant's service plan. The service worker, case manager, health home coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restraints would be addressed with the provider of service and corrected as needed.

The State also contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restraints. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines participant files, and conducts targeted reviews based on complaints, to ascertain whether restraints are appropriately incorporated into the service plan, such that restraints are only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of restraints. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service participants that alert service workers, case managers, and health home coordinators, and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of restraints, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The HCBS Quality Assurance and Technical Assistance Unit is also responsible for conducting IPES

interviews with waiver participants. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the individual interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver participant. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

Finally, the Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of restraints, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The DHS policy regarding restrictive interventions is as follows, and applies to all types of restrictions that may be used by waiver providers. The policy described in this section applies regardless of delivery system (i.e., FFS participants or MCO members), and MCOs are contractually obligated to adhere. A restrictive intervention is an action or procedure that limits a participant's movement, access to other individuals, locations or activities, or restricts a participant's rights. The use of any restrictive interventions as part of the waiver program is treated as rights limitations of the participant receiving services. As a rights limitation, the restrictive intervention must be agreed to by the interdisciplinary team and identified in the participant's plan of care (441 Iowa Administrative Code Chapter 83).

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
e. Corporal punishment and verbal or physical abuse are prohibited."

These safeguards are the same regardless of what restrictions are used. All restrictions must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All participants served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Restrictions may be designed and implemented only for the benefit of the person and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

The service worker, case manager, health home coordinator, or community-based case manager has the responsibility to assess the need for the restrictive interventions, identify the specific restrictive intervention, explain why the intervention is being used, identify an intervention plan, monitor the use of the restrictive intervention, and assess and reassess need for continued use. The service plan authorizes the services to be delivered to the participant and identifies how they are to be provided. Without the authorization, services cannot be provided to a participant. Providers are required to use the service plan as the basis for the development and implementation of the providers' treatment plan. The provider is responsible for developing a plan to meet the needs of the member and to train all staff on the implementation strategies of the treatment plan, such that the interventions are individualized and in accordance with the previously devised plan. Providers and the service worker, case manager, health home coordinator, or community-based case manager are responsible for documenting all behavioral interventions, including restrictive interventions, in the service plan as well as the participant's response to the intervention. Providers and service worker, case manager, health home coordinator, or community-based case manager are also required to submit critical incident reports to the BLTC care, via the IMPA, any time a restrictive intervention is utilized.

Providers are required to maintain a system for the review, approval and implementation of ethical, safe, humane and efficient behavioral intervention procedures, that inform the participant and his/her legal guardian of the behavioral intervention policy and procedures at the time of entry into a facility and as changes occur. Non-aversive methods of intervention must be designed and utilized as the option of first use, prior to design or implementation of any behavioral intervention containing aversive techniques.

Behavioral intervention procedures may be designed and implemented only for the benefit of the participant and may never be used merely as punishment or for the convenience of the staff or as a substitute for a nonaversive program. Behavioral intervention procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the individual's Behavioral Intervention Program. Corporal punishment and verbal or physical abuse are prohibited. Restrictions may only be used for reducing or eliminating maladaptive target behaviors that are identified in the individual's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:

- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of restrictions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Restrictions and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. A person's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (i) the supervisor's ability to implement the procedure has

been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Restrictions and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a person's right to be free from aversive, intrusive procedures is balanced against the person's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter an individual's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the individual's service plan and the service worker, case manager, health home coordinator, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements.

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the person's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the individual and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the Behavioral Intervention Program must include:

- Approval by the individual's interdisciplinary team, with the written consent of the person's parent if the person is under eighteen years of age, or the person's legal guardian, if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the person's health.
- A functional analysis that is defined as and includes the following components: (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior; (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors; (iii) description of the conditions that precede the behavior in question; (iv) description of what appears to reinforce and maintain the behavior; and (v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the individual, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Restrictions must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All restrictions are explained to the individual and their legal representative and agreed upon ahead of time.

Unauthorized use of restrictions would be detected via interviews with the participant, their family and staff and services worker, health home coordinator, or community-based case manager; through review of critical incident reports by DHS and participant's services worker, health home coordinator, or community-based case manager on a daily basis; DHS and services worker, health home coordinator, or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints). Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review

documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the DHS policy for each type of agency identified restriction is observed and participant rights are safeguarded. If it is found that a waiver provider is not observing DHS policy or ensuring a participant's rights, adverse action is taken by the IME, which may include sanction, termination, required corrective action, etc.

The HCBS Quality Assurance and Technical Assistance Unit is also responsible for conducting IPES interviews with waiver participants. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the individual interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver participant. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

The participant's service worker, case manager, health home coordinator, or community-based case manager, is responsible to monitor individual plans of care including the use of restrictions and behavioral interventions.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The first line of responsibility for overseeing the use of restrictions and ensuring safeguards are in place is the participant's service worker, case manager, health home coordinator, or community based case manager. The use of restrictions must be assessed as needed and identified in the individual participant's service plan. The use of restrictions would also require the development and implementation of a behavior plan and the plan would be included in the participant's service plan. The service worker, case manager, health home coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restrictions would be addressed with the provider of service and corrected as needed.

The State contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restrictions. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines participant files, and conducts targeted reviews based on complaints, to ascertain whether restrictions are appropriately incorporated into the service plan, such that restrictions are only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of restrictions. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service participants that alert service workers, case managers, health home coordinators, or community-based case managers and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of restrictions, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The HCBS Quality Assurance and Technical Assistance Unit is also responsible for conducting IPES interviews with waiver participants. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the individual interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver participant. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

Finally, the Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of restrictions, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DHS policy regarding seclusion is as follows, and applies to all types of seclusions that may be used by waiver providers, regardless of delivery system (i.e., FFS participants or MCO members). Examples of seclusion include but are not limited to locking an individual in a room, locking an individual out of an area of their residence, or limiting community time. All incidents of seclusion must be documented in the member's service record and reported to the IME as a critical incident. As a rights limitation, the seclusion procedures must be agreed to by the interdisciplinary team and identified in the participant's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of seclusion must be documented in a participant's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
e. Corporal punishment and verbal or physical abuse are prohibited."

These safeguards are the same regardless of what seclusions are used. All seclusions must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All participants

served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Seclusion procedures may be designed and implemented only for the benefit of the person and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

Seclusion may be allowed depending on the provider's agency policy to ensure that there is an accompanying behavioral intervention plan, documentation of each instance, and monitoring of its use. Seclusion be considered on an individual basis after the interdisciplinary team reviews them, and entered into the written plan of care with specific time lines. If a participant were placed in a closed room the time frame would need to be determined on an individual basis and spelled out in the service plan. The provider would need to document the use of this seclusion in the participant's service file each time it was utilized by staff. The provider would be required to have a written policy approved by DHS on the supervision and monitoring of participants placed in a closed room such as monitoring on a fifteen minute basis for example to assure the health and welfare of the participant.

Seclusion procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the individual's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:

- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of seclusions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Seclusions and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. A person's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (i) the supervisor's ability to implement the procedure has been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Seclusion and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a person's right to be free from aversive, intrusive procedures is balanced against the person's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter an individual's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the individual's service plan and the service worker, case manager, health home coordinator, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements.

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the person's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.

- Use the least restrictive intervention possible.
- Ensure the health and safety of the individual and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:

- Approval by the individual's interdisciplinary team, with the written consent of the person's parent if the person is under eighteen years of age, or the person's legal guardian, if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the person's health.
- A functional analysis that is defined as and includes the following components: (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior; (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors; (iii) description of the conditions that precede the behavior in question; (iv) description of what appears to reinforce and maintain the behavior; and (v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the individual, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Seclusions must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All seclusions are explained to the individual and their legal representative and agreed upon ahead of time.

Unauthorized use of seclusion would be detected via interviews with the participant, their family and staff and services worker, health home coordinator, or community-based case manager; through review of critical incident reports by DHS and participant's services worker, health home coordinator, or community-based case manager on a daily basis; DHS and services worker, health home coordinator, or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints). Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the DHS policy for each type of agency identified seclusion is observed and participant rights are safeguarded. If it is found that a waiver provider is not observing DHS policy or ensuring a participant's rights, adverse action is taken by the IME, which may include sanction, termination, required corrective action, etc.

The participant's service worker, case manager, health home coordinator, or community-based case manager, is responsible to monitor individual plans of care including the use of seclusion and behavioral interventions.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The first line of responsibility for overseeing the use of seclusion and ensuring safeguards are in place is the participant's service worker, case manager, health home coordinator, or community based case manager. The use of seclusion must be assessed as needed and identified in the individual participant's service plan. The use of seclusion would also require the development and implementation of a behavior plan and the plan would be included in the participant's service plan. The service worker, case manager, health home coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of seclusion would be addressed with the provider of service and corrected

as needed.

The State contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with seclusion. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines participant files, and conducts targeted reviews based on complaints, to ascertain whether seclusion is appropriately incorporated into the service plan, such that seclusion is only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of seclusion. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service participants that alert service workers, case managers, health home coordinators, or community-based case managers and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of seclusion, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The HCBS Quality Assurance and Technical Assistance Unit is also responsible for conducting IPES interviews with waiver participants. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the individual interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver participant. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

Finally, the Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of seclusion, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

This requirement is only applicable in those situations where the member is receiving respite services outside the family home. Per 441 Iowa Administrative Code 77.46(5), respite providers must meet the following requirements as a condition of providing respite care under the children's mental health waiver: (1) training on

provision of medication according to agency policy and procedure; and (2) the staff member shall not provide any direct service without the oversight of supervisory staff until training is completed.

The service worker, case manager, health home coordinator, or community-based case manager, and any provider responsible for medication administration must monitor the documentation of medication administration to ensure adherence to the service plan and provider policies and procedure. The provider agency frequently and routinely monitors as outlined in their policies and procedures, and quality improvement plans. Provider agencies are expected to review medication administration on a daily basis to ensure health and welfare of participant as well as perform quality assurance on a timeframe identified by the agency (most often monthly). The service worker, case manager, health home coordinator, or community-based case manager also monitor during the annual service plan development.

Monitoring includes review of the service documentation to ensure that medications have been administered at the designated times and by designated individuals. Further monitoring occurs through the report of major incidents whenever a medication error results in physicians' treatment, mental health intervention, law enforcement intervention, death, or elopement. When a major incident has occurred, follow-up, investigation, and remediation occurs as identified in G. l .d. All medication errors resulting in a major incident report or discovered via complaint are fully investigated. If it is determined that a harmful practice has been detected, the provider agency completes a corrective action plan and may face sanctions depending on severity and negligence of the circumstance.

The Iowa Medicaid program has actively managed Medicaid pharmacy benefits through a Preferred Drug List (PDL) since 2005. A governor appointed medical assistance pharmaceutical and therapeutics (P&T) committee was established for the purpose of developing and providing ongoing review of the PDL. The prior authorization department of the IME MSU utilizes the PDL to review medication management. First line responsibility lies with the prescriber who is contacted by fax or telephone regarding a prescription. Pharmacists review patient profiles for proper diagnosis, dosage strength and length of therapy.

The DHS Member Services Unit has established procedures to monitor Medicaid members' prescribing physicians and pharmacies. Analysis has established risk thresholds for these factors to mitigate possible abuse, harmful drug reactions, and to improve the outcomes of medication regimes for Medicaid members. When it is identified that members exceed the established risk thresholds, the member is placed in lock-in. Lock-in establishes one prescribing physician and one filling pharmacy for each member. The Member Services Unit also conducts statistical analysis of the use of certain drugs and usage patterns. Identification of trends for prescriptions and usage patterns of high risk or addictive medications is presented to DHS on a monthly or quarterly basis.

The Drug Utilization Review (DUR) Commission is a quality assurance body, which seeks to improve the quality of pharmacy services and ensure rational, cost-effective medication therapy for Medicaid recipients in Iowa. The commission reviews policy issues and provides suggestions on prospective DUR criteria, prior authorization guidelines, OTC coverage, and plan design issues. The DUR system provides for the evaluation of individual patient profiles by a qualified professional group of physicians and pharmacists, with expertise in the clinically appropriate prescribing of covered outpatient drugs, the clinically appropriate dispensing and monitoring of outpatient drugs, drug use review, evaluations and intervention, and medical quality assurance. Members of this group also have the knowledge, ability, and expertise to target and analyze therapeutic appropriateness, inappropriate long-term use of medication, overuse/underuse/abuse/polypharmacy, lack of generic use, drug-drug interactions, drug-disease contraindications, therapeutic duplications, therapeutic benefit issues, and cost-effective drug strengths and dosage forms. In addition, the IME MSU reviews Medicaid member records to ensure that the member had a diagnosis or rational documented for each medication taken.

The Department of Inspections and Appeals (DIA) is responsible for Medicaid member's medication regimes for waiver participants served in an RCF/ID. All medical regimes are included in the participant's record. Medications administered by the facility are recorded on a medical record by the individual who administers medication. All RCF/IDs are licensed facilities and must meet all Department of Inspections Administrative Rules to obtain an annually renewable license. Medical records are reviewed during licensure renewal. Persons administrating medication must be a licensed nurse or physician or have successfully completed a department approved medication aide course. If the provider stores handles prescribes dispenses or administers prescription or over the counter medications the provider is required to develop procedures for the storage handling prescribing dispensing or administration of medication. For controlled substances, providers

must maintain DIA procedures. If the provider has a physician on staff or under contract, the physician must review and document the provider's prescribed medication regime at least annually in accordance with current medical practice. Policies and procedures must be developed in written form by the provider for the dispensing, storage, and recording of all prescription and nonprescription medications administered, monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, including antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics. Policies and procedures are reviewed by the HCBS Specialists for compliance with state and federal regulations. If deficiencies are found, the provider is required to submit a corrective action, and follow-up surveys may be conducted based on the severity of the deficiency.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Second line responsibility is utilized when issues are more complex. Occurrences of high dosage use for certain medications or prescribing drugs for an age group where the drug is not FDA indicated are sent to DHS-IME for review. In some cases edits have been placed in the computer system so the prescriber could not prescribe for age groups not indicated.

Lock-In: Trending and analysis has been conducted by the MSU and “lock-in” strategies have been implemented for individuals who have, historically, multiple prescribers and pharmacies. Identification of these individuals allows the Medicaid payment of only one prescribing physician and one pharmacy. This allows for increased monitoring of appropriate medication management and mitigates the risk associated with pharmacological abuses and negative contraindications.

Drug Utilization Review (DUR) Commission: The DUR is a second line monitoring process with oversight by DHS. The DUR system includes a process of provider intervention that promotes quality assurance of care, patient safety, provider education, cost effectiveness and positive provider relations. Letters to providers generated as a result of the professional evaluation process identify concerns about medication regimens and specific patients. At least one Iowa licensed pharmacist is available to reply in writing to questions submitted by providers regarding provider correspondence, to communicate by telephone with providers as necessary and to coordinate face-to-face interventions as determined by the DUR.

The Department of Inspections and Appeals (DIA): This DIA is responsible for oversight of licensed facilities. DIA communicates all findings to DHS and any issues identified during the RCF/ID licensure process, or critical incidents as they arise. The DIA tracks information and provides training as necessary to improve quality. This information is also shared with DHS. Both the DIA and DHS follow-up with identified RCF/IDs to assure that action steps have been made to ensure potential harmful practices do reoccur.

HCBS Quality Assurance Unit: DHS contracts with the Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restraints and seclusion. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines participant files, and conducts targeted reviews based on complaints, to ascertain whether restraints and seclusions are appropriately incorporated into the service plan, such that restraints and seclusion are only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of restraints and seclusion. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service participants that alert service workers, case managers, and health home coordinators, and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of restraints and/or seclusion, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and

possible sanctions (suspension, probation, termination, etc.) may apply.

The Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of restraints and seclusion, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Respite Service providers must have policies and procedures developed for dispensing, storage, and recording all prescription and nonprescription medication administered. 441 Iowa Administrative Code Chapters 77.30(3)(b)(2), 77.33(6) (b)(2), 77.34(5) (b)(2), 77.37(15) (b)(2), 77.39(14) (b)(2), and 77.46(5)(e) state:

"Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing. All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name. In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription."

Providers are required to have staff trained on medication administration and provide safe oversight of medication administration. The State does not require specific medication administration curriculum to be used. Providers are responsible to assure that staff has the skills needed to administer medications safely. There are no uniform requirements in the Iowa Administrative Code for the provision of medication administration or for the self-administration of medications by Medicaid members.

The Provider Self-Assessment quality improvement process requires providers to have a policy and procedure for the storage and provision of medication. This process requires a more uniform approach for the provider in the requirements for medication management. The Provider Self-Assessment review checklist used by the HCBS Specialist to review providers identifies the following minimum standards that the medication policy will identify:

- The provider's role in the management and/or administration of medications
- If staff administers medications, the policy will identify the: (1) training provided to staff prior to the administration of medications; (2) method of documenting the administration of medications; (3) storage of medications; (4) the assessment process used to determine the Medicaid member's role in the administration of medications.

The provider Self-Assessment process also requires providers to have discovery, remediation and improvement processes for medication administration. The information and results of these activities is available to DHS upon request. Currently the self-assessment process is not set forth in the Iowa Administrative Code.

Home Health agencies that provide waiver services must follow Medicare regulations for medication administration and dispensing. All medications must be stored in their original containers with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to Medicaid members and the public. Nonprescription medications shall be labeled with the Medicaid member's name. In the case of medications that are administered on an ongoing long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription. All providers of respite must develop policies that assure that personnel that administer medications have the appropriate skills and that there is oversight by medical personnel.

Provider non-medical waiver staff that administers medications must have oversight of a licensed nurse. If the medication requires, the staff is required to complete a medication management course through a community college.

The requirements for non-medical waiver providers must have in order to administer medications to Medicaid members who cannot self-administer is that the provider must have a written policy in place on what the requirements are for their staff to do this and how. If the medications are psychiatric medications the person would have to have successfully completed a medication aide class. Oversight for a staff member who administers medications that require oversight such as in the case of psychiatric medications would need to follow the requirements as spelled out through the Board of Nursing such as having oversight by a registered nurse. The HCBS Specialists through IME would oversee this policy upon regular reviews of the provider.

State oversight responsibility is described in Appendix H for the monitoring methods that include identification of problems in provider performance and support follow-up remediation actions and quality improvement activities.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Providers are required to complete incidents reports for all occurrences meeting the criteria for major and minor incidents and make the incident reports and related documentation available to DHS upon request. Major incidents must be reported to the BLTC via IMPA. Providers must ensure cooperation in providing pertinent information regarding incidents as requested by DHS.

As part of the major incident reporting process described in Appendix G-1, DHS will review and follow-up on all medication errors that lead to a participant hospitalization or death. This can include the wrong dosage, the wrong medication delivered, medication delivered at the wrong time, Medicaid delivery not documented, unauthorized administration of medication, or missed dosage. Providers are required to submit all medication errors, whether major or minor, to the participant's service worker, case manager, health home coordinator, or community-based case manager when they occur. The service worker, case manager, health home coordinator, or community-based case manager monitors the errors and makes changes to the participant's service plan as needed to assure the health and safety of the member.

The Provider Self-Assessment quality improvement process requires providers to have a policy and procedure regarding medication administration and medication management. The Provider Self-Assessment process also requires that providers have discovery, remediation, and improvement processes for medication administration and medication errors. Specifically, providers are required to have ongoing review of medication management and administration to ensure that medications are managed and administered appropriately. Providers are also required to track and trend all medication errors to assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to DHS upon request and will be reviewed as part of the ongoing Self-Assessment process conducted by the HCBS Specialists. This will include random sampling of providers, incident specific review (complaint and IR follow up) and on-site provider review held every five years. DHS is in the process of promulgating rules to establish the Provider Self-Assessment quality improvement process in the Administrative Code.

Other professionals or family members may report medication error incidents at any time as a complaint. Suspected abuse is reported to the reporting hotline operated by the Department of Human Services.

(b) Specify the types of medication errors that providers are required to *record:*

Providers must track and trend all major and minor incident reports. Per Chapter 441 Iowa Administrative Code 77.25(1), "major incidents" are defined as an occurrence involving a participant during service provision that: (1) results in a physical injury to or by the participant that requires a physician's treatment or admission to a hospital; (2) results in the death of any person; (3) requires emergency mental health treatment for the participant; (4) requires the intervention of law enforcement; (5) requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; (6) constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or (7) involves a participant's location being unknown by provider staff who are assigned protective oversight. Service providers, provider staff, service workers, case managers, health home coordinators, and community-based case managers are required to submit incident reports as they are witnessed or discovered. All major incidents must be reported within 48 hours of witnessing or discovering an incident has occurred, using the IME's Iowa Medicaid Portal Access (IMPA) System. Suspected abuse may be reported to the statewide abuse reporting hotline operated by DHS.

Per Chapter 441 Iowa Administrative Code 77.25(1), "minor incidents" are defined as an occurrence involving a participant during service provision that is not a major incident and that: (1) results in the application of basic first aid; (2) results in bruising; (3) results in seizure activity; (4) results in injury to self, to others, or to property; or (5) constitutes a prescription medication error. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the participant's file.

Providers are required to record all medication errors, both major and minor, that occur. Providers are required to track and trend all medication errors and assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to DHS upon request and will be reviewed as part of the ongoing Self-Assessment process conducted by the HCBS Specialists.

(c) Specify the types of medication errors that providers must *report* to the State:

Only major incidents of medication errors that affect the health and safety of the participant, as defined by the major incident criteria, are required to be reported to the State. All medication errors, both major and minor, are required to be reported to the member's guardian, service worker, case manager, health home coordinator, or community-based case manager.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The BLTC is responsible for the oversight of waiver providers in the administration of medications to waiver participants. Oversight monitoring is completed through IMPA, the provider Self-Assessment process and monitoring of the participant by the participant's service worker, case manager, health home coordinator, or community-based case manager. All of these processes have been described in detail in this Appendix.

All medication errors are considered either major or minor incidents, as noted in Subsection "iii.b" above. These major incidents are reported to the department and follow the incident reporting follow up protocol of the department.

DHS contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with medication administration. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines participant files, and conducts targeted reviews based on complaints, to ascertain whether restraints and seclusions are appropriately incorporated into the service plan, such that medication is only administered as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate medication administration. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service participants that alert service workers, case managers, and health home coordinators, and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding medication administration, the provider is required to complete a CAP and implement the CAP to 100% compliance. Again, if it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The Unit compiles all data related to incidents reported in IMPA associated with the inappropriate medication administration, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*
   i. **Sub-Assurances:**

      a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

      Performance Measures

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

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

      Performance Measure:

HW-4a: Number and percent of unexplained, suspicious or untimely deaths compared to the total number of deaths. Numerator = # of major incidents reporting unexplained, suspicious or untimely deaths Denominator = # of major incidents reporting death

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
IMPA reports are generated by the HCBS Incident Reporting Specialist. This data on suspicious or untimely deaths is inductively analyzed on a monthly, quarterly and annual basis.

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

Data Aggregation and Analysis:

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

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

Performance Measure:
HW-5a: Number and percent of member survey respondents who reported they feel safe in their living environment. Numerator = # of suveys reporting member feels safe in living environment Denominator = # of suveys

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
The IPES survey is conducted at a 95% confidence level and responses recorded in a database. Data is pulled and inductively analyzed.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
HW-6a: Number and percent of experience/satisfaction survey respondents who reported that someone hit or hurt them physically. Numerator = # of survey respondents reporting that member was hit/hurt Denominator = # of survey respondents

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
The IPES survey is conducted at a 95% confidence level and responses recorded in a database. Data is pulled and inductively analyzed.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
HW-7a: Number and percent of experience/satisfaction survey respondents who reported they do not feel safe with the people they live with. Numerator = # of survey respondents reporting member does not feel safe with the people they live with Denominator = # of survey respondents

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
The IPES survey is conducted at a 95% confidence level and responses recorded in a database. Data is pulled and inductively analyzed.

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 = 5%
☑ **Other** Specify: Contracted Entity including MCOs	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
HW-1a: Number, percent and frequency of major incidents, by type. Numerator = # of each type of major incident reported Denominator = # of major incidents reported

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
IMPA reports are generated by the HCBS Incident Reporting Specialist. This data on incidents is inductively analyzed on a monthly, quarterly, and annual basis.

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

Data Aggregation and Analysis:

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

Performance Measure:

HW-2a: Number and percent of major incidents that were reported within required timeframes as specified in the approved waiver. Numerator = # of major incidents reported timely (within 48 hours) Denominator = # of major incidents reported.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
IMPA reports are generated by the HCBS Incident Reporting Specialist. This data on incidents is inductively analyzed on a monthly, quarterly, and annual basis.

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

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
HW-8a: The number and percentage of restrictive interventions applied that were not in the member's service plan, or were not applied as indicated in the service plan. Numerator = # of reviews where restrictive interventions were applied that were not in the member's service plan, or were not applied as indicated in the service plan; Denominator = total # of reviews

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☑ **Other** Specify: Contracted Entity including MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
HW-3a: Number and percent of medication errors that resulted in a waiver participant requiring medical treatment. Numerator = # of major incidents reporting medication errors resulting in medical treatment Denominator = # of major incidents reporting medication errors.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
IMPA reports are generated by the HCBS Incident Reporting Specialist. This data on incidents is inductively analyzed on a monthly, quarterly, and annual basis.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **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 HCBS Quality Assurance unit is responsible for monitoring and analyzing data associated with the major incidents reported to the state, via IMPA, for members on waivers. Data is pulled from the data warehouse and from MCO reporting on a regular basis for programmatic trends, individual issues and operational concerns.

Reported incidents of abuse, medication error, death, rights restrictions, and restraints are investigated further by the HCBS Incident Reporting Specialist on a monthly basis. The analysis of this data is presented to the state on a monthly and quarterly basis.

The HCBS provider oversight unit is responsible for conducting IPES interviews with waiver members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the individual interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The HCBS Incident Reporting Specialist analyzes data for individual and systemic issues. Individual issues require communication with the service worker to document all efforts to remediate risk or concern. If a these efforts are not successful, the IR Specialist continues efforts to communicate with the service worker, the service worker's supervisor, and protective services when necessary. All remediation efforts of this type are documented in the monthly and quarterly reports.

The HCBS Specialists conducting interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the service worker is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis.
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: MCOs	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. **System Improvements**

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The IME is the single state agency that retains administrative authority of Iowa's HCBS Waivers. Iowa remains highly committed to continually improve the quality of services for all waiver programs. The IME discovered over the course of submitting previous 1915(c) waiver evidence packages that previously developed performance measures were not adequately capturing the activities of the IME. For this reason, state staff developed new performance measures to better capture the quality processes that are already occurring or being developed. The QIS developed by Iowa stratifies all 1915(c) waivers.

Based on contract oversight and performance measure implementation, the IME holds weekly policy staff and long term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff. Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance group gathers on a monthly basis to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level.

All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas. The QM/QI program must have objectives that are measurable, realistic and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 subpart D and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program.

Iowa has acknowledged that improvements are necessary to capture data at a more refined level, specifically individual remediation. While each contracting unit utilizes their own electronic tracking system or OnBase (workflow management), further improvements must be made to ensure that there are not preventable gaps collecting individual remediation. The State acknowledges that this is an important component of the system; however the terrain where intent meets the state budget can be difficult to manage.

The Balancing Incentive Payment Program allows for infrastructure development that ensures choice is provided to all Medicaid members seeking services and that these services are allocated at the most appropriate level possible. This will increase efficiency as less time is spent on service/funding allocation and more time is spent on care coordination and improvement. A comprehensive system of information and referrals ensures that all individuals are allowed fully informed choices prior to facility placement.

A comprehensive system of information and referrals shall also be developed such that all individuals are allowed fully informed choices prior to facility placement. Most of these changes shall be posted for external bid and implemented during 2015 and 2016. Many program integrity and ACA initiatives will assist in system improvements. These include improvements to provider screening at enrollment, tighter sanction rules, and more emphasis on sustaining quality practices.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify:	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
Contracted Entity (Including MCOs)	

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The IME has hired a Quality Assurance Manager to oversee the data compilation and remediation activities associated with the revised performance measures. The QA Manager and State policy staff address oversight of design changes and the subsequent monitoring and analysis during the weekly policy and monthly quality assurance meetings. Prior to dramatic system design changes, the State will seek the input of stakeholders and test/pilot changes that are suggested and developed. Informational letters are sent out to all relevant parties prior to implementation with contact information of key staff involved. This workflow is documented in logs and in informational letters found within the DHS computer server for future reference. Stakeholder involvement and informational letters are requested or sent out on a weekly/monthly/ongoing basis as policy engages in the continuous quality improvement cycle.

Unit managers, policy staff and the QA committee continue to meet on a regular basis (weekly or monthly) to monitor performance and work plan activities. The IME Management and QA committees include representatives from the contracted units within the IME as well as State staff. These meetings serve to present and analyze data to determine patterns, trends, concerns, and issues in service delivery of Medicaid services, including by not limited to waiver services. Based on these analyses, recommendations for changes in policy are made to the IME policy staff and bureau chiefs. This information is also used to provide training, technical assistance, corrective action, and other activities. The unit managers and committees monitor training and technical assistance activities to assure consistent implementation statewide. Meeting minutes/work plans track data analysis, recommendations, and prioritizations to map the continuous evaluation and improvement of the system. IME analyzes general system performance through the management of contract performance benchmarks, ISIS reports, and Medicaid Value Management reports and then works with contractors, providers and other agencies regarding specific issues. The QA committee directs workgroups on specific activities of quality improvement and other workgroups are activated as needed.

In addition to developing QM/QI programs that include regular, ongoing assessment of services provided to Medicaid beneficiaries, MCOs must maintain a QM/QI Committee that includes medical, behavioral health, and long-term care staff, and network providers. This committee is responsible for analyzing and evaluating the result of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action, and ensuring appropriate follow-up. This committee is also responsible for reviewing and approving the MCOs' QM/QI program description, annual evaluation, and associated work plan prior to submission to DHS.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The IME reviews the overall QIS no less than annually. Strategies are continually adapted to establish and sustain better performance through improvements in skills, processes, and products. Evaluating and sustaining progress toward system goals is an ongoing, creative process that has to involve all stakeholders in the system. Improvement requires structures, processes, and a culture that encourage input from members at all levels within the system, sophisticated and thoughtful use of data, open discussions among people with a variety of perspectives, reasonable risk-taking, and a commitment to continuous learning. The QIS is often revisited more often due to the dynamic nature of Medicaid policies and regulations, as well as the changing climate of the member and provider communities.

In accordance with 42 CFR 438.202, the State will maintain a written strategy for assessing and improving the quality of services offered by MCOs including, but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries. MCOs must comply with the standards established by the State and must provide all information and reporting necessary for the State to carry out its obligations for the State quality strategy. In accordance with 42 CFR 438.204, the State will

regularly monitor and evaluate the MCOs' compliance with the standards established in the State's quality strategy and the MCOs' QM/QI program.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The IME Program Integrity (PI) unit conducts audits on all Medicaid Provider types including HCBS providers. Any suspected fraud is turned over to the Department of Inspection and Appeals Medicaid Fraud and Control Unit.
The PI Unit must open a minimum of 60 cases for provider reviews during each quarter. Cases referred from DHS must be opened in the quarter referred. Reviewed cases must include providers who exceed calculated norms for rates and units as well as a random sample. Reviews are also incorporated through referrals and complaints received. All reviews include monitoring a statistically representative sample of paid claims and service documentation to detect such aberrancies as up-coding or code creep. This monitoring may involve desk reviews or provider on-site reviews.
PI must also perform on-site reviews on at least 5% of provider cases opened during the quarter. This translates into a minimum of 3 on-site reviews per quarter. They must also include analysis of provider practice patterns and reviews of medical records in the provider's setting. PI must initiate appropriate action to recover erroneous/inappropriate provider payments on the basis of its reviews. They must work with the Core MMIS contractor to accomplish required actions on providers, including requests to recover payment through the use of credit and adjustment procedures. During a desk review the provider is required to submit records for review. The purpose of the site visit is to verify that the information submitted to the State is accurate and to determine compliance with Federal and State enrollment requirements.
PI must report findings from all reviews to DHS, including quarterly written reports (or more frequent if requested) detailing information on provider utilization review summary findings and provider on-site review activity. Requests for provider records by the PI unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)"d" to document the basis for services or activities provided.
Audits are conducted in accordance with 441 Iowa Administrative Code 79.4(3) – 5, which provides the following: "79.4 (3) Audit or review procedures. The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.
a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph 'b.'
b. Extension of time limit for submission.
(1)The department may grant and extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:
1.Establish good cause for the delay in submitting the records; and
2.Be received by the department before the date the records are due to be submitted.
(2)For purposes of these rules,'good cause' has the same meaning as in Iowa Rule of Civil Procedure 1.977.
(3)The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.
(4)The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.
c.The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.
(1)For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.
(2)Notice is not required for unannounced on-site reviews and audits.
(3)In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.
d.Audit or review procedures may include, but are not limited to, the following:
(1)Comparing clinical and financial records with each claim.
(2)Interviewing members who receive goods or services and employees of providers.

(3)Examining third-party payment records.
(4)Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.
(5)Examining all documents related to the services for which Medicaid was billed.
e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.
(1)A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.
(2)Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.
(3)Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.
(4)The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.
f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.
79.4(4) Preliminary report of audit or review findings. If the department concludes from an auditor review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.
79.4(5) Disagreement with audit or review findings. If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.
a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.
(1)If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.
(2)If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.
b. Additional information. A provider that has made a reevaluation request pursuant to paragraph 'a' of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph 'c' of this subrule.
c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:
(1)Be arranged and paid for by the provider.
(2)Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
(3)Be conducted by a certified public accountant if the issues relate to fiscal records.
(4)Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.
(5)Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.
The DHS fiscal agent also conducts audits on providers of HCBS. The 100 highest billing providers (account for over 70% of year's expenditures) are identified and reviewed on a 3-5 year cycle. This sample is compared to the reviews conducted by the PI Unit to avoid duplication. An electronic program is utilized to randomly pick member files from the list of potential providers as well as the months to be reviewed. From the statistically representative sample, 10% of member files are reviewed to ensure proper billing procedures and supporting service documentation. Providers are also subject to Payment Error Rate Measurement (PERM) audits. The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the fee-for-service, managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review.
The Auditor of the State has the responsibility to conduct periodic independent audit of the waiver under the provisions of the Single Audit Act. All HCBS cost reports will be subject to desk review audit and, if necessary, a field audit.
MCOs are responsible for safeguarding against the potential for and investigating reports of suspected fraud and abuse.

MCOs are required to fully cooperate with the DHS PI Unit by providing data and ongoing communication and collaboration. Per 42 CFR 438.608 and 42 CFR 455, MCOs must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The Program Integrity Plan must be updated annually and submitted to DHS for review and approval. On a monthly basis, the MCO must submit an activity report to DHS, which outlines the MCO's program integrity-related activities and findings, progress in meeting goals and objectives and recoupment totals. The MCO must, at minimum, include the name and NPI of provider reviewed, reason for review, review outcome, provider referrals to Iowa's Medicaid Fraud Control Unit, providers suspended and terminated, provider recoupment amount, provider payment reductions, providers denied enrollment/reenrollment, and State fiscal year to date summary information.
MCOs must also coordinate all program integrity efforts with IME personnel, DPH personnel and Iowa's Medicaid Fraud Control Unit. MCOs must have in place a method to verify whether services reimbursed were actually furnished to members as billed by providers, and must comply with 42 CFR 455.23 by suspending all payments to a provider after DHS determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual/entity unless otherwise directed by DHS or law enforcement. MCOs shall comply with all requirements for provider disenrollment and termination as required by 42 CFR §455.416.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**

      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
FA-1a: Number and percent of reviewed paid claims for which the units of service were coded as specified in the approved waiver. Numerator = # of reviewed paid claims that were coded as specified Denominator = # of reviewed paid claims

Data Source (Select one):
Financial audits
If 'Other' is selected, specify:
The Program Integrity unit requests service documentation from providers and cross-walks with claims. This data is inductively analyzed.

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):*
	☐ **Weekly**	☐ **100% Review**

☐ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: The Program Integrity Unit utilizes an algorithm that establishes providers exceeding the norm rate and unit charged. These providers are reviewed quarterly.
	☐ **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:

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

Performance Measure:
FA-2a: Number and percent of reviewed paid claims for which the units of service lacked supporting documentation. Numerator = # of reviewed paid claims lacking supporting documentation Denominator = # of reviewed paid claims

Data Source (Select one):
Financial audits
If 'Other' is selected, specify:
The Program Integrity unit requests service documentation from providers and cross-walks with claims. This data is inductively analyzed.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: The Program Integrity Unit utilizes an algorithm that establishes providers exceeding the norm rate and unit charged. These providers are reviewed quarterly.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

Performance Measure:
FA-3a: Number and percent of reviewed exception to policy (ETP) requests for which rates were paid using the methodology other than specified in the approved waiver. Numerator = # of reviewed ETPs that were paid using methodology other than as specified; Denominator = # of reviewed ETPs.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

		Confidence Interval =
☑ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: The Medical Services Unit reports quarterly on ETP trends. This data is analyzed inductively.
	☐ **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 Program Integrity unit samples provider claims each quarter for quality. These claims are cross-walked with service documentation to determine the percentage of error associated with coding and documentation. This data is stored in in a spreadsheet and reported on a monthly and quarterly basis.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments, require screening of all claims, referral to MFCU, or provider suspension.

The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a monthly and quarterly basis.

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 Financial Accountability that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Adult day care, counseling, personal emergency response, home-delivered meals, homemaker, home and vehicle modification, respite (unless detailed otherwise below), and nutritional counseling are reimbursed by fee schedules.

Consumer directed attendant care services, both skilled and unskilled, are reimbursed based on the agreement of the

member and the provider. Services have an upper maximum rate limit established in the Iowa Administrative Code. Minimum rates must comply with minimum wage requirements. The member and provider can agree upon a rate that is between the Iowa Minimum Wage and the maximum rate allowed per the Iowa Administrative Code. The overall waiver caps for members still apply. Members whose needs surpass the waiver caps or the limitations on consumer directed attendant care services funding can request an exception to policy.

Respite rates for services provided by a home health agency are a cost-based rate for nursing or home health aide services provided by that agency. The cost-based rate uses the maximum Medicare or Medicare rate converted to an hourly rate, whichever is lower.

For services that the member self-directs (self-directed personal care, Individual-directed goods and services, and self-directed community support and employment) the member negotiates a rate for the entity providing services, goods and supports, except for the Financial Management Service (FMS) and Independent Support Broker. FMS follow a fee schedule as described above. For Independent Support Broker services the upper limit is set by a fee schedule but the payment rate is negotiated between the member and the broker.

Home Health Aide and Nursing Services are based on a fee schedule as determined by Medicare.

Interim medical monitoring and treatment service rates are a cost based rate for home health aide or nursing services provided by a home health agency. The Iowa Medicaid Enterprise, through the provider auditing and rate setting unit, is responsible for rate setting.

441 Iowa Administrative Code 79.1 sets forth the principles governing reimbursement of providers of medical and health services. Specifically, "[t]he basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member. Reimbursement types are described at 441 Iowa Administrative Code 79.1(1):

"a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:
(1) The actual charge made by the provider of service.
(2) The maximum allowance under the fee schedule for the item of service in question.
Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988. There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15). Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule.

d. Fee for service with cost settlement. Providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).
(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.
(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:
1. The indirect administrative costs shall be limited to 23 percent of other costs. Other costs include: professional staff – direct salaries, other – direct salaries, benefits and payroll taxes associated with direct salaries, mileage and automobile rental, agency vehicle expense, automobile insurance, and other related transportation.
2. Mileage shall be reimbursed at a rate no greater than the state employee rate.
3. The rates a provider may charge are subject to limits established at 79.1(2).
4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1)‘e’(3).
(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider’s reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.
(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.
(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1 (2) and to retrospective adjustment based on the provider’s actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.”

All provider rates are part of Iowa Administrative Code and are subject to public comment any time there is change. This information is on the website as well as distributed to stakeholders when there is a change. At the time of service plan development, the case managers shares with the members the rates of the providers, and the member can chose a provider based on their rates.

MCO capitation rate development methodologies are described in the §1915(b) waiver and associated materials.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

For fee-for-service participants, providers shall submit claims on a monthly basis for waiver services provided to each member served by the provider agency. Providers may submit manual or electronic claim forms. Electronic claims must utilize a HIPAA compliant software, PC-ACE Pro 32, and shall be processed by the IME Provider Services Unit. Manual claims shall be directed to the Iowa Medicaid Enterprise (IME)/Provider Services Unit.

Providers shall submit a claim form that accurately reflects the following: (1) the provider's approved NPI provider number; (2) the appropriate waiver procedure code(s) that correspond to the waiver services authorized in the ISIS service plan; and (3) the appropriate waiver service unit(s) and fee that corresponds to the ISIS service plan.

The IME issues provider payments weekly on each Monday of the month. The MMIS system edits insure that payment will not be made for services that are not included in an approved ISIS service plan. Any change to ISIS data generates a new authorization milestones for the case manager. The ISIS process culminates in a final ISIS milestone that verifies an approved service plan has been entered into ISIS. ISIS data is updated daily into MMIS.

For MCO members, providers bill the managed care entity with whom a member is enrolled in accordance with the

terms of the provider's contract with the MCO.

Provider billing manuals and fee schedules are available on the IME website: http://dhs.iowa.gov/ime/providers/csrp.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS system edits to make sure that claim payments are made only when an individual is eligible for waiver payments and when the services are included in the service plan. An individual is eligible for a Medicaid Waiver payment on the date of service as verified in ISIS. The billing validation method includes the date the service was provided, time of service provision, and name of actual person providing the service. Several entities monitor the validity of claim payments: (1) the service worker, case manager, or health home coordinator ensures that the services were provided by reviewing paid claims information made available to them for each of their members through ISIS; (2) the Iowa Department of Human Services Bureau of Purchased Services performs financial audits of providers to ensure that the services were provided; (3) the IME Program Integrity Unit performs a variety of reviews by either random sample or outlier algorithms.

The MMIS system includes system edits to ensure that prior to issuing a capitation payment to an MCO the member is eligible for the waiver program and is enrolled with the MCO. The MCOs are required to develop and maintain an electronic community-based case management system that captures and tracks service delivery against authorized services and providers. The State monitors MCO compliance and system capability through pre-implementation

readiness reviews and ongoing monitoring such as a review of sampled payments to ensure that services were provided and were included in the enrollee's approved plan of care. The MCOs are also responsible for program integrity functions with DHS review and oversight.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ◉ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

  Payments for waiver services for fee-for-service enrollees are made by DHS through the MMIS. Capitation payments to MCOs are made by the MMIS. The MMIS has recipient eligibility and MCO assignment information. When a recipient is enrolled in an MCO, this is reflected on his/her eligibility file and monthly payment flows from the MMIS to the MCO via an 837 transaction. A monthly payment to the MCO on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For fee-for-service enrollees, for the self-direction option of the waivers, payments will be made to a financial management service, which will be designated by the state as an organized healthcare delivery system to make payments to the entities providing support and goods for members that self-direct. The financial management service must meet provider qualifications established by the state and pass a readiness review approved by the state and be enrolled as a Medicaid provider with the state. The state will also oversee the operations of the financial management service by provide periodical audits.

The fiscal agent mails to entities providing support and goods for members that self-direct information how they can bill Medicaid directly if they choose. IME exercise oversight of the fiscal agent through both the ISIS system and through our "Core" unit. IME has regularly scheduled meetings with Core that has thresholds of measurements they are required to meet to assure quality.

When a provider has been enrolled as a Medicaid provider, IME Provider Services mails the provider an enrollment packet that includes how the provider can bill Medicaid directly. The Provider billing manual is also available on the Iowa DHS website at: http://dhs.iowa.gov/policy-manuals/medicaid-provider.

☑ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

N/A

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ○ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ◉ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

For fee-for-service enrollees, providers receive and retain 100% of the amount claimed to CMS for waiver services. The payment to capitated MCOs is reduced by a performance withhold amount as outlined in the contracts between DHS and the MCOs. The MCOs are eligible to receive some or all of the withheld funds based on the MCO's performance in the areas outlined in the contract between DHS and the MCOs.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ( ) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- (●) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

Enrolled Medicaid providers can choose to subcontract to non-enrolled providers for the provision of Home and Vehicle Modifications and Assistive Devices. The authorization for the service and the Medicaid payment for the authorized service is made to the enrolled Medicaid provider that would then forward payment to the subcontractor in accordance with their contract. Any subcontractor who is qualified to enroll with Iowa Medicaid is encouraged to do so. No provider is denied Medicaid enrollment for those services that they are qualified to provide. Waiver providers are not required to contract with an OHCDS in order to furnish services to participants. When the service worker, case manager, health home coordinator or community-based case manager has assessed the need for any waiver service, the member is offered the full choice of available providers. The member has the right to choose from the available providers; the list of providers is available through the service worker, case manager, health home coordinator or community-based case manager, and is also available through the IME and MCO websites. In accordance with the Iowa Administrative Code, all subcontractors must meet the same criteria guidelines as enrolled providers and the contracting enrolled provider must confirm that all criteria is met.

The Financial Management Services entities are designated as an OHCDS as long as they meet provider qualifications as specified in C-3. Iowa Medicaid Enterprise (the state Medicaid agency) executes a provider agreement with the OHCDS providers and MCOs contract with an IME enrolled Financial Management Services solution. The Financial Management Services provided by the OHCDS is voluntary and an alternative billing and access is provided to both waiver participants and providers. Participants have free choice of providers both within the OHCDS and external to these providers. Providers may use the alternative certification and billing process developed by the Iowa Medicaid Enterprise. Participants are given this information during their service plan development. Providers are given this information by the OHCDS. The Designated OHCDS reviews and certifies that established provider qualifications have been met for each individual or vendor receiving Medicaid reimbursement. Annually each provider will be recertified as a qualified provider. Employer/employee agreements and timesheets document the services provided if waiver participants elect to hire and manage their own workers. The purchase of goods and services is documented through receipts and/or invoices. For each purchase for fee-for-service participants, Medicaid funding from the MMIS to the provider of the service is accurately and appropriately tracked through the use of Iowa's ISIS system. Financial oversight and monitoring of the OHCDS is administered by the Iowa Medicaid Enterprise through an initial readiness review to determine capacity to perform the waiver services and throughout the year using a reporting system, random case file studies and the regular Medicaid audit process. MCOs are contractually required to develop a system to track all OHCDS

Financial Management Services, which is subject to DHS review and approval. Further, the MCOs maintain financial oversight and monitoring with ongoing review and authority retained by DHS.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- ○ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ○ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ◉ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- ☑ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- ☐ **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- ◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**
Check each that applies:
☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
○ **The following source(s) are used**
Check each that applies:
☐ **Health care-related taxes or fees**
☐ **Provider-related donations**
☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

As specified in Iowa Administrative Code, Iowa does not reimburse for room and board costs, except as noted for providers of out of home respite services. The provider manuals contain instructions for providers to follow when providing financial information to determine rates. It states that room and board cannot be included in the cost of

providing services. Most respite payments are based upon fee schedules detailed in the Iowa Administrative Code. That fee schedule has no allowance for room and board charges. Respite provided by a home health agency is limited to the established Medicare rate.

The exclusion of room and board from reimbursement is ensured by the Provider Cost Audit Unit. When providers submit cost report documentation and rate setting changes, the Provider Cost Audit Unit accounts for all line items and requests justification for all allocated costs (administrative and other). If it is determined that a provider has attempted to include room and board expenses in cost audits or rate setting documentation, the provider is instructed to make the adjustment and further investigation is conducted to determine if previous reimbursement needs to be recouped by the Iowa Medicaid Enterprise.

All providers of waiver services are subject to a billing audit completed by the Department of Human Services Bureau of Purchased services.

Any payment from an MCO to residential settings is made explicitly for the provision of services as defined by this waiver and excludes room and board. As part of the ongoing monitoring process of MCOs, the State will ensure that payments to residential settings are based solely on service costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	6859.05	20398.00	27257.05	26703.00	8527.00	35230.00	7972.95
2	7073.17	21214.00	28287.17	27237.00	8868.00	36105.00	7817.83
3	8705.45	22063.00	30768.45	27781.00	9222.00	37003.00	6234.55
4	9117.05	25474.12	34591.17	28337.00	9591.00	37928.00	3336.83
5	9261.97	26108.25	35370.22	28904.00	9975.00	38879.00	3508.78

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Nursing Facility	Level of Care: ICF/IID
Year 1	3762	3552	210
Year 2	4036	3810	226
Year 3	3080	2907	173
Year 4	3226	3045	181
Year 5	3377	3188	189

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Based on the most recent 372 report approved and accepted by CMS regional office.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Prior to 01/2016 - From the 372 reports with a 3.3% increase each year in costs. Unduplicated recipients increased by 571 in the first year and 7.3% in the second due to a waiting list buydown. The third year is based off current enrollment, plus an estimated 426 recipients being added due to a legislatively approved buydown of the waiting list.

After 01/2016 - Values were derived from actuarily sound capitation rates for HCBS services.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Prior to 01/2016 - No Part D drugs are included in D'. D' projections are a 4% increase and based on the current usage reflected on the 372 reports.

After 01/2016 - Values were derived from actuarily sound capitation rates for State Plan services.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Based on the 2009 MMIS Data and the most recent 372 report with an increase of 2% per year based on past history.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Based on the 2009 MMIS Data and the most recent 372 report with an increase of 4% per year based on past history.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Adult Day	
Homemaker	
Respite	
Home Health Aide	
Nursing	
Financial Management Services	
Independent Support Broker	
Self-Directed Community Support and Employment	
Consumer Directed Attendant Care - Skilled	
Consumer-Directed Attendant Care - Unskilled	
Counseling Service	
Home and Vehicle Modification	
Home Delivered Meals	
Individual Directed Goods and Services	
Interim Medical Monitoring and Treatment	
Monthly capitation payments	
Nutritional Counseling	
Personal Emergency Response	
Self-directed Personal Care	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Total:							**66493.86**
daily	☐	daily	9	117.00	47.20	**49701.60**	
Half Day	☐	Half Day	3	90.00	29.79	**8043.30**	
Extended Day	☐	Extended Day	1	132.00	66.28	**8748.96**	
Homemaker Total:							**1265142.24**
Homemaker	☐	hourly	376	162.00	20.77	**1265142.24**	
Respite Total:							**9692533.77**
Home Health Aide - Specialized	☐	hourly	106	432.00	38.85	**1779019.20**	
Home Health Aide - Basic Individual	☐	hourly	112	320.00	24.54	**879513.60**	
Home Health Aide - Group	☐	hourly	1	409.00	12.73	**5206.57**	
Respite-Home Care Agency & Non-Facility, Specialized	☐	hourly	11	358.00	34.59	**136215.42**	
Respite-Home Care Agency & Non-Facility, Basic Individual	☐	hourly	646	560.00	16.06	**5809865.60**	
Respite-Home Care Agency & Non-Facility - Group	☐	hourly	155	457.00	11.83	**837978.05**	
Hospital or Nursing Facility/Skilled	☐	hourly	1	4464.00	18.98	**84726.72**	
Child Care	☐	hourly	3	135.00	12.95	**5244.75**	
Resident Camp-Weeklong	☐	hourly	4	1449.00	3.88	**22488.48**	
Group Specialized Summer Day Camp	☐	hourly	10	613.00	12.16	**74540.80**	
Teen Day Camp	☐	hourly	1	701.00	11.58	**8117.58**	

GRAND TOTAL:	**25803732.73**
Total: Services included in capitation:	
Total: Services not included in capitation:	25803732.73
Total Estimated Unduplicated Participants:	**3762**
Factor D (Divide total by number of participants):	**6859.05**
Services included in capitation:	
Services not included in capitation:	6859.05
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Weekend On-site Respite Camp		hourly	9	596.00	9.25	49617.00	
Home Health Aide Total:							30320.73
Home Health Aide		hourly	3	297.00	34.03	30320.73	
Nursing Total:							612696.72
Nursing		hourly	8	1789.00	42.81	612696.72	
Financial Management Services Total:							248272.08
Monthly		monthly	238	12.00	86.93	248272.08	
Independent Support Broker Total:							1.00
Independent Support Broker		monthly	1	1.00	1.00	1.00	
Self-Directed Community Support and Employment Total:							488347.44
Monthly		monthly	238	12.00	170.99	488347.44	
Consumer Directed Attendant Care - Skilled Total:							821682.55
Agency Provider		hourly	15	458.00	19.45	133621.50	
Agency Provider Day		hourly	1	288.00	30.30	8726.40	
Individual Provider		hourly	53	947.00	12.07	605805.37	
Individual Provider Day		hourly	4	363.00	50.64	73529.28	
Consumer-Directed Attendant Care - Unskilled Total:							7386298.50
Agency Provider		hourly	139	458.00	19.45	1238225.90	
Agency Provider Day		hourly	1	288.00	30.30	8726.40	
Individual Provider		hourly	476	947.00	12.07	5440818.04	
Individual Provider Day		hourly	38	363.00	50.64	698528.16	
Counseling Service Total:							2.00
Counseling Service		hourly				1.00	

GRAND TOTAL:	**25803732.73**
Total: Services included in capitation:	
Total: Services not included in capitation:	25803732.73
Total Estimated Unduplicated Participants:	**3762**
Factor D (Divide total by number of participants):	**6859.05**
Services included in capitation:	
Services not included in capitation:	6859.05
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			1	1.00	1.00		
Counseling Individual		hourly	1	1.00	1.00	1.00	
Home and Vehicle Modification Total:							577528.80
Monthly		monthly	20	12.00	2406.37	577528.80	
Home Delivered Meals Total:							1367500.60
Morning Meal		meal	42	285.00	6.99	83670.30	
Noon Meal		meal	362	307.00	7.37	819057.58	
Evening Meal		meal	176	299.00	7.82	411519.68	
Liquid Supplement		meal	31	436.00	3.94	53253.04	
Individual Directed Goods and Services Total:							194208.00
Monthly		monthly	238	12.00	68.00	194208.00	
Interim Medical Monitoring and Treatment Total:							888800.92
IMMT		hourly	3	705.00	17.94	37943.10	
HHA Aide		hourly	29	578.00	26.21	439332.02	
HHA Nurse		hourly	25	299.00	40.60	303485.00	
Child Care		hourly	8	1090.00	12.39	108040.80	
Monthly capitation payments Total:							0.00
Monthly capitation payments		monthly	0	0.00	0.01	0.00	
Nutritional Counseling Total:							1006.08
Nutritional Counseling		hourly	2	48.00	10.48	1006.08	
Personal Emergency Response Total:							172922.32
Install		install	11	1.00	537.72	5914.92	
Monthly		monthly	440	12.00	31.63	167006.40	
Portable Locator						1.00	

GRAND TOTAL:	**25803732.73**
Total: Services included in capitation:	
Total: Services not included in capitation:	25803732.73
Total Estimated Unduplicated Participants:	**3762**
Factor D (Divide total by number of participants):	**6859.05**
Services included in capitation:	
Services not included in capitation:	6859.05
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		monthly	1	1.00	1.00		
Self-directed Personal Care Total:							**1989975.12**
Self-directed Personal Care	☐	monthly	238	12.00	696.77	**1989975.12**	
				GRAND TOTAL:			**25803732.73**
				Total: Services included in capitation:			
				Total: Services not included in capitation:			25803732.73
				Total Estimated Unduplicated Participants:			**3762**
				Factor D (Divide total by number of participants):			**6859.05**
				Services included in capitation:			
				Services not included in capitation:			6859.05
				Average Length of Stay on the Waiver:			329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Total:							**68692.92**
daily	☐	daily	9	117.00	48.76	**51344.28**	
Half Day	☐	Half Day	3	90.00	30.78	**8310.60**	
Extended Day	☐	Extended Day	1	132.00	68.47	**9038.04**	
Homemaker Total:							**1403859.60**
Homemaker	☐	hourly	404	162.00	21.45	**1403859.60**	
Respite Total:							**10732516.43**
Home Health Aide - Specialized	☐	hourly	114	432.00	40.13	**1976322.24**	
Home Health Aide - Basic Individual	☐	hourly	120	320.00	25.35	**973440.00**	
						5378.35	
				GRAND TOTAL:			**28547300.74**
				Total: Services included in capitation:			
				Total: Services not included in capitation:			28547300.74
				Total Estimated Unduplicated Participants:			**4036**
				Factor D (Divide total by number of participants):			**7073.17**
				Services included in capitation:			
				Services not included in capitation:			7073.17
				Average Length of Stay on the Waiver:			329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Health Aide - Group		hourly	1	409.00	13.15		
Respite-Home Care Agency & Non-Facility, Specialized		hourly	12	358.00	35.74	**153539.04**	
Respite-Home Care Agency & Non-Facility, Basic Individual		hourly	693	560.00	16.59	**6438247.20**	
Respite-Home Care Agency & Non-Facility - Group		hourly	166	457.00	12.22	**927033.64**	
Hospital or Nursing Facility/Skilled		hourly	1	4464.00	19.61	**87539.04**	
Child Care		hourly	3	135.00	13.38	**5418.90**	
Resident Camp-Weeklong		hourly	4	1449.00	4.01	**23241.96**	
Group Specialized Summer Day Camp		hourly	10	613.00	12.57	**77054.10**	
Teen Day Camp		hourly	1	701.00	11.96	**8383.96**	
Weekend On-site Respite Camp		hourly	10	596.00	9.55	**56918.00**	
Home Health Aide Total:							**31318.65**
Home Health Aide		hourly	3	297.00	35.15	**31318.65**	
Nursing Total:							**679140.00**
Nursing		hourly	9	1750.00	43.12	**679140.00**	
Financial Management Services Total:							**274788.00**
Monthly		monthly	255	12.00	89.80	**274788.00**	
Independent Support Broker Total:							**1.00**
Independent Support Broker		monthly	1	1.00	1.00	**1.00**	
Self-Directed Community Support and Employment Total:							**540518.40**
Monthly		monthly	255	12.00	176.64	**540518.40**	
Consumer Directed Attendant Care - Skilled Total:							**914507.39**
Agency Provider		hourly	17	458.00	20.09	**156420.74**	
Agency Provider Day						**9014.40**	

GRAND TOTAL:	**28547300.74**
Total: Services included in capitation:	
Total: Services not included in capitation:	28547300.74
Total Estimated Unduplicated Participants:	**4036**
Factor D (Divide total by number of participants):	**7073.17**
Services included in capitation:	
Services not included in capitation:	7073.17
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		hourly	1	288.00	31.30		
Individual Provider		hourly	57	947.00	12.47	**673118.13**	
Individual Provider Day		hourly	4	363.00	52.31	**75954.12**	
Consumer-Directed Attendant Care - Unskilled Total:							**8162173.28**
Agency Provider		hourly	149	458.00	20.09	**1370981.78**	
Agency Provider Day		hourly	1	288.00	31.30	**9014.40**	
Individual Provider		hourly	510	947.00	12.47	**6022635.90**	
Individual Provider Day		hourly	40	363.00	52.31	**759541.20**	
Counseling Service Total:							**2.00**
Counseling Service		hourly	1	1.00	1.00	**1.00**	
Counseling Individual		hourly	1	1.00	1.00	**1.00**	
Home and Vehicle Modification Total:							**641331.24**
Monthly		monthly	258	1.00	2485.78	**641331.24**	
Home Delivered Meals Total:							**1517202.69**
Morning Meal		meal	45	285.00	7.22	**92596.50**	
Noon Meal		meal	389	307.00	7.62	**910003.26**	
Evening Meal		meal	189	299.00	8.07	**456043.77**	
Liquid Supplement		meal	33	436.00	4.07	**58559.16**	
Individual Directed Goods and Services Total:							**214965.00**
Monthly		monthly	255	12.00	70.25	**214965.00**	
Interim Medical Monitoring and Treatment Total:							**974449.98**
IMMT		hourly	3	705.00	18.54	**39212.10**	
HHA Aide						**485040.26**	

GRAND TOTAL:	**28547300.74**
Total: Services included in capitation:	
Total: Services not included in capitation:	28547300.74
Total Estimated Unduplicated Participants:	**4036**
Factor D (Divide total by number of participants):	**7073.17**
Services included in capitation:	
Services not included in capitation:	7073.17
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		hourly	31	578.00	27.07		
HHA Nurse		hourly	27	299.00	41.94	338581.62	
Child Care		hourly	8	1090.00	12.80	111616.00	
Monthly capitation payments Total:							**0.00**
Monthly capitation payments		monthly	0	0.00	0.01	0.00	
Nutritional Counseling Total:							**1038.72**
Nutritional Counseling		hourly	2	48.00	10.82	1038.72	
Personal Emergency Response Total:							**188299.24**
Install		install	12	1.00	271.28	3255.36	
Monthly		monthly	472	12.00	32.67	185042.88	
Portable Locator		monthly	1	1.00	1.00	1.00	
Self-directed Personal Care Total:							**2202496.20**
Self-directed Personal Care		monthly	255	12.00	719.77	2202496.20	

GRAND TOTAL:	**28547300.74**
Total: Services included in capitation:	
Total: Services not included in capitation:	28547300.74
Total Estimated Unduplicated Participants:	**4036**
Factor D (Divide total by number of participants):	**7073.17**
Services included in capitation:	
Services not included in capitation:	7073.17
Average Length of Stay on the Waiver:	329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Total:							**65972.04**
daily	☐	daily	8	117.00	53.42	**50001.12**	
Half Day	☐	Half Day	2	90.00	33.72	**6069.60**	
Extended Day	☐	Extended Day	1	132.00	75.01	**9901.32**	
Homemaker Total:							**1303102.08**
Homemaker	☐	15 Mintues	342	648.00	5.88	**1303102.08**	
Respite Total:							**10000763.04**
Home Health Aide - Specialized	☐	15 Minutes	97	1728.00	10.99	**1842099.84**	
Home Health Aide - Basic Individual	☐	15 Minutes	102	1280.00	6.94	**906086.40**	
Home Health Aide - Group	☐	15 Minutes	1	1636.00	3.60	**5889.60**	
Respite-Home Care Agency & Non-Facility, Specialized	☐	15 Minutes	10	1432.00	9.79	**140192.80**	
Respite-Home Care Agency & Non-Facility, Basic Individual	☐	15 Minutes	587	2240.00	4.55	**5982704.00**	
Respite-Home Care Agency & Non-Facility - Group	☐	15 Minutes	141	1828.00	3.35	**863455.80**	
Hospital or Nursing Facility/Skilled	☐	15 Minutes	1	18656.00	5.37	**100182.72**	
Child Care	☐	15 Minutes	3	540.00	3.67	**5945.40**	
Resident Camp-Weeklong	☐	15 Minutes	3	5796.00	1.10	**19126.80**	
Group Specialized Summer Day Camp	☐	15 Minutes	9	2452.00	3.44	**75913.92**	
Teen Day Camp	☐	15 Minutes	1	2804.00	3.28	**9197.12**	
Weekend On-site Respite Camp	☐	15 Minutes	8	2384.00	2.62	**49968.64**	
Home Health Aide Total:							**22880.88**
Home Health Aide	☐	15 Minutes	2	1188.00	9.63	**22880.88**	
Nursing Total:							**613200.00**
Nursing	☐	15 Minutes				**613200.00**	

GRAND TOTAL:	**26812788.40**
Total: Services included in capitation:	
Total: Services not included in capitation:	26812788.40
Total Estimated Unduplicated Participants:	**3080**
Factor D (Divide total by number of participants):	**8705.45**
Services included in capitation:	
Services not included in capitation:	8705.45
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			12	7000.00	7.30		
Financial Management Services Total:							**255545.28**
Monthly	☐	monthly	216	12.00	98.59	**255545.28**	
Independent Support Broker Total:							**1.00**
Independent Support Broker	☐	monthly	1	1.00	1.00	**1.00**	
Self-Directed Community Support and Employment Total:							**667906.56**
Monthly	☐	monthly	216	12.00	257.68	**667906.56**	
Consumer Directed Attendant Care - Skilled Total:							**864505.12**
Agency Provider	☐	15 Minutes	14	1940.00	5.50	**149380.00**	
Agency Provider Day	☐	15 Minutes	1	2304.00	4.29	**9884.16**	
Individual Provider	☐	15 Minutes	48	3788.00	3.42	**621838.08**	
Individual Provider Day	☐	15 Minutes	4	5808.00	3.59	**83402.88**	
Consumer-Directed Attendant Care - Unskilled Total:							**7672726.32**
Agency Provider	☐	15 Minutes	126	1940.00	5.50	**1344420.00**	
Agency Provider Day	☐	15 Minutes	1	2304.00	4.29	**9884.16**	
Individual Provider	☐	15 Minutes	433	3788.00	3.42	**5609497.68**	
Individual Provider Day	☐	15 Minutes	34	5808.00	3.59	**708924.48**	
Counseling Service Total:							**2.00**
Counseling Service	☐	15 Minutes	1	1.00	1.00	**1.00**	
Counseling Individual	☐	15 Minutes	1	1.00	1.00	**1.00**	
Home and Vehicle Modification Total:							**596400.51**
Monthly	☐	monthly	219	1.00	2723.29	**596400.51**	
Home Delivered Meals Total:							**1410676.73**

GRAND TOTAL:	**26812788.40**
Total: Services included in capitation:	
Total: Services not included in capitation:	26812788.40
Total Estimated Unduplicated Participants:	**3080**
Factor D (Divide total by number of participants):	**8705.45**
Services included in capitation:	
Services not included in capitation:	8705.45
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Morning Meal		meal	39	285.00	7.91	87919.65	
Noon Meal		meal	330	307.00	8.34	844925.40	
Evening Meal		meal	160	299.00	8.85	423384.00	
Liquid Supplement		meal	28	436.00	4.46	54447.68	
Individual Directed Goods and Services Total:							199895.04
Monthly		monthly	216	12.00	77.12	199895.04	
Interim Medical Monitoring and Treatment Total:							912199.96
IMMT		15 Minutes	3	2820.00	5.08	42976.80	
HHA Aide		15 Minutes	26	2312.00	7.42	446031.04	
HHA Nurse		15 Minutes	23	1196.00	11.49	316066.92	
Child Care		15 Minutes	7	4360.00	3.51	107125.20	
Monthly capitation payments Total:							0.00
Monthly capitation payments		monthly	0	0.00	0.01	0.00	
Nutritional Counseling Total:							1140.48
Nutritional Counseling		15 Minutes	2	192.00	2.97	1140.48	
Personal Emergency Response Total:							177336.00
Install		install	10	1.00	554.30	5543.00	
Monthly		monthly	400	12.00	35.79	171792.00	
Portable Locator		monthly	1	1.00	1.00	1.00	
Self-directed Personal Care Total:							2048535.36
Self-directed Personal Care		monthly	216	12.00	790.33	2048535.36	

GRAND TOTAL:	**26812788.40**
Total: Services included in capitation:	
Total: Services not included in capitation:	26812788.40
Total Estimated Unduplicated Participants:	**3080**
Factor D (Divide total by number of participants):	**8705.45**
Services included in capitation:	
Services not included in capitation:	8705.45
Average Length of Stay on the Waiver:	329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Total:							**11357.76**
daily	☐	daily	8	19.50	55.18	**8608.08**	
Half Day	☐	Half Day	2	15.00	34.83	**1044.90**	
Extended Day	☐	Extended Day	1	22.00	77.49	**1704.78**	
Homemaker Total:							**224201.52**
Homemaker	☐	15 Minutes	342	108.00	6.07	**224201.52**	
Respite Total:							**1720760.08**
Home Health Aide - Specialized	☐	15 Minutes	97	288.00	11.35	**317073.60**	
Home Health Aide - Basic Individual	☐	15 Minutes	102	213.30	7.17	**155994.82**	
Home Health Aide - Group	☐	15 Minutes	1	272.70	3.69	**1006.26**	
Respite-Home Care Agency & Non-Facility, Specialized	☐	15 Minutes	10	238.70	10.11	**24132.57**	
Respite-Home Care Agency & Non-Facility, Basic Individual	☐	15 Minutes	587	373.30	4.70	**1029897.37**	
Respite-Home Care Agency & Non-Facility - Group	☐	15 Minutes	141	304.70	3.46	**148650.94**	
Hospital or Nursing Facility/Skilled	☐	15 Minutes	1	3109.30	5.31	**16510.38**	
Child Care	☐	15 Minutes	3	90.00	3.79	**1023.30**	
Resident Camp-Weeklong	☐	15 Minutes	3	966.00	1.14	**3303.72**	

GRAND TOTAL:	**29411612.68**
Total: Services included in capitation:	
Total: Services not included in capitation:	29411612.68
Total Estimated Unduplicated Participants:	**3226**
Factor D (Divide total by number of participants):	**9117.05**
Services included in capitation:	
Services not included in capitation:	9117.05
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Specialized Summer Day Camp		15 Minutes	9	408.70	3.56	13094.75	
Teen Day Camp		15 Minutes	1	467.30	3.19	1490.69	
Weekend On-site Respite Camp		15 Minutes	8	397.30	2.70	8581.68	
Home Health Aide Total:							3940.20
Home Health Aide		15 Minutes	2	198.00	9.95	3940.20	
Nursing Total:							105283.01
Nursing		15 Minutes	12	1166.70	7.52	105283.01	
Financial Management Services Total:							43994.88
Monthly		Monthly	216	2.00	101.84	43994.88	
Independent Support Broker Total:							0.20
Independent Support Broker		Monthly	1	0.20	1.00	0.20	
Self-Directed Community Support and Employment Total:							114989.76
Monthly		monthly	216	2.00	266.18	114989.76	
Consumer Directed Attendant Care - Skilled Total:							148749.07
Agency Provider		15 Minutes	14	323.30	5.69	25754.08	
Agency Provider Day		15 Minutes	1	384.00	4.43	1701.12	
Individual Provider		15 Minutes	48	631.30	3.53	106967.47	
Individual Provider Day		15 Minutes	4	968.00	3.70	14326.40	
Consumer-Directed Attendant Care - Unskilled Total:							1320197.96
Agency Provider		15 Minutes	126	323.30	5.69	231786.70	
Agency Provider Day		15 Minutes	1	384.00	4.43	1701.12	
Individual Provider		15 Minutes	433	631.30	3.53	964935.74	
Individual Provider Day		15 Minutes	34	968.00	3.70	121774.40	

GRAND TOTAL:	**29411612.68**
Total: Services included in capitation:	
Total: Services not included in capitation:	29411612.68
Total Estimated Unduplicated Participants:	**3226**
Factor D (Divide total by number of participants):	**9117.05**
Services included in capitation:	
Services not included in capitation:	9117.05
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Counseling Service Total:							**0.40**
Counseling Service	☐	15 Minutes	1	0.20	1.00	**0.20**	
Counseling Individual	☐	15 Minutes	1	0.20	1.00	**0.20**	
Home and Vehicle Modification Total:							**123216.41**
Monthly	☐	occurrance	219	0.20	2813.16	**123216.41**	
Home Delivered Meals Total:							**243008.61**
Morning Meal	☐	meal	39	47.50	8.18	**15153.45**	
Noon Meal	☐	meal	330	51.20	8.62	**145643.52**	
Evening Meal	☐	meal	160	49.80	9.14	**72827.52**	
Liquid Supplement	☐	meal	28	72.70	4.61	**9384.12**	
Individual Directed Goods and Services Total:							**34417.44**
Monthly	☐	monthly	216	2.00	79.67	**34417.44**	
Interim Medical Monitoring and Treatment Total:							**156964.32**
IMMT	☐	15 Minutes	3	470.00	5.25	**7402.50**	
HHA Aide	☐	15 Minutes	26	385.30	7.66	**76736.35**	
HHA Nurse	☐	15 Minutes	23	199.30	11.87	**54410.89**	
Child Care	☐	15 Minutes	7	726.70	3.62	**18414.58**	
Monthly capitation payments Total:							**24777034.92**
Monthly capitation payments	☐	monthly	3226	9.00	853.38	**24777034.92**	
Nutritional Counseling Total:							**195.84**
Nutritional Counseling	☐	15 Minutes	2	32.00	3.06	**195.84**	
Personal Emergency Response Total:							**30606.86**
Install	☐	install	10	0.20	515.33	**1030.66**	

GRAND TOTAL:	**29411612.68**
Total: Services included in capitation:	
Total: Services not included in capitation:	29411612.68
Total Estimated Unduplicated Participants:	**3226**
Factor D (Divide total by number of participants):	**9117.05**
Services included in capitation:	
Services not included in capitation:	9117.05
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Monthly	☐	monthly	400	2.00	36.97	29576.00	
Portable Locator	☐	monthly	1	0.20	1.00	0.20	
Self-directed Personal Care Total:							352693.44
Self-directed Personal Care	☐	monthly	216	2.00	816.42	352693.44	

GRAND TOTAL:	29411612.68
Total: Services included in capitation:	
Total: Services not included in capitation:	29411612.68
Total Estimated Unduplicated Participants:	3226
Factor D (Divide total by number of participants):	9117.05
Services included in capitation:	
Services not included in capitation:	9117.05
Average Length of Stay on the Waiver:	329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Total:							0.00
daily	☐	daily	0	0.00	0.01	0.00	
Half Day	☐	Half Day	0	0.00	0.01	0.00	
Extended Day	☐	Extended Day	0	0.00	0.01	0.00	
Homemaker Total:							0.00
Homemaker	☐	15 Minutes	0	0.00	0.01	0.00	
Respite Total:							0.00
Home Health Aide - Specialized	☐	15 Minutes	0	0.00	0.01	0.00	
						0.00	

GRAND TOTAL:	31277679.44
Total: Services included in capitation:	
Total: Services not included in capitation:	31277679.44
Total Estimated Unduplicated Participants:	3377
Factor D (Divide total by number of participants):	9261.97
Services included in capitation:	
Services not included in capitation:	9261.97
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Health Aide - Basic Individual	☐	15 Minutes	0	0.00	0.01		
Home Health Aide - Group	☐	15 Minutes	0	0.00	0.01	0.00	
Respite-Home Care Agency & Non-Facility, Specialized	☐	15 Minutes	0	0.00	0.01	0.00	
Respite-Home Care Agency & Non-Facility, Basic Individual	☐	15 Minutes	0	0.00	0.01	0.00	
Respite-Home Care Agency & Non-Facility - Group	☐	15 Minutes	0	0.00	0.01	0.00	
Hospital or Nursing Facility/Skilled	☐	15 Minutes	0	0.00	0.01	0.00	
Child Care	☐	15 Minutes	0	0.00	0.01	0.00	
Resident Camp-Weeklong	☐	15 Minutes	0	0.00	0.01	0.00	
Group Specialized Summer Day Camp	☐	15 Minutes	0	0.00	0.01	0.00	
Teen Day Camp	☐	15 Minutes	0	0.00	0.01	0.00	
Weekend On-site Respite Camp	☐	15 Minutes	0	0.00	0.01	0.00	
Home Health Aide Total:							0.00
Home Health Aide	☐	15 Minutes	0	0.00	0.01	0.00	
Nursing Total:							0.00
Nursing	☐	15 Minutes	0	0.00	0.01	0.00	
Financial Management Services Total:							0.00
Monthly	☐	monthly	0	0.00	0.01	0.00	
Independent Support Broker Total:							0.00
Independent Support Broker	☐	monthly	0	0.00	0.01	0.00	
Self-Directed Community Support and Employment Total:							0.00
Monthly	☐	monthly	0	0.00	0.01	0.00	
Consumer Directed Attendant Care - Skilled Total:							0.00
Agency Provider	☐					0.00	

GRAND TOTAL:	**31277679.44**
Total: Services included in capitation:	
Total: Services not included in capitation:	31277679.44
Total Estimated Unduplicated Participants:	**3377**
Factor D (Divide total by number of participants):	**9261.97**
Services included in capitation:	
Services not included in capitation:	9261.97
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 Minutes	0	0.00	0.01		
Agency Provider Day	☐	15 Minutes	0	0.00	0.01	**0.00**	
Individual Provider	☐	15 Minutes	0	0.00	0.01	**0.00**	
Individual Provider Day	☐	15 Minutes	0	0.00	0.01	**0.00**	
Consumer-Directed Attendant Care - Unskilled Total:							**0.00**
Agency Provider	☐	15 Minutes	0	0.00	0.01	**0.00**	
Agency Provider Day	☐	15 Minutes	0	0.00	0.01	**0.00**	
Individual Provider	☐	15 Minutes	0	0.00	0.01	**0.00**	
Individual Provider Day	☐	15 Minutes	0	0.00	0.01	**0.00**	
Counseling Service Total:							**0.00**
Counseling Service	☐	15 Minutes	0	0.00	0.01	**0.00**	
Counseling Individual	☐	15 Minutes	0	0.00	0.01	**0.00**	
Home and Vehicle Modification Total:							**0.00**
Monthly	☐	monthly	0	0.00	0.01	**0.00**	
Home Delivered Meals Total:							**0.00**
Morning Meal	☐	meal	0	0.00	0.01	**0.00**	
Noon Meal	☐	meal	0	0.00	0.01	**0.00**	
Evening Meal	☐	meal	0	0.00	0.01	**0.00**	
Liquid Supplement	☐	meal	0	0.00	0.01	**0.00**	
Individual Directed Goods and Services Total:							**0.00**
Monthly	☐	monthly	0	0.00	0.01	**0.00**	
Interim Medical Monitoring and Treatment Total:							**0.00**
IMMT	☐					**0.00**	

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Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 Minutes	0	0.00	0.01		
HHA Aide		15 Minutes	0	0.00	0.01	**0.00**	
HHA Nurse		15 Minutes	0	0.00	0.01	**0.00**	
Child Care		15 Minutes	0	0.00	0.01	**0.00**	
Monthly capitation payments Total:							**31277679.44**
Monthly capitation payments		monthly	3377	10.80	857.59	**31277679.44**	
Nutritional Counseling Total:							**0.00**
Nutritional Counseling		15 Minutes	0	0.00	0.01	**0.00**	
Personal Emergency Response Total:							**0.00**
Install		install	0	0.00	0.01	**0.00**	
Monthly		monthly	0	0.00	0.01	**0.00**	
Portable Locator		monthly	0	0.00	0.01	**0.00**	
Self-directed Personal Care Total:							**0.00**
Self-directed Personal Care		monthly	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**31277679.44**
Total: Services included in capitation:	
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Total Estimated Unduplicated Participants:	**3377**
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Services included in capitation:	
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Average Length of Stay on the Waiver:	329