## Appendix C: Participant Services

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

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

| Service Type | Service |
|---|---|
| Statutory Service | Adult Day Care |
| Statutory Service | Day Habilitation |
| Statutory Service | Prevocational Services |
| Statutory Service | Residential Based Supported Community Living |
| Statutory Service | Respite |
| Statutory Service | Supported Employment |
| Extended State Plan Service | Home Health Aide Servies |
| Extended State Plan Service | Nursing |
| Supports for Participant Direction | Financial Management Services |
| Supports for Participant Direction | Independent Support Broker |
| Supports for Participant Direction | Individual Directed Goods and Services |
| Supports for Participant Direction | Self Directed Community Support and Employment |
| Supports for Participant Direction | Self Directed Personal Care |
| Other Service | Consumer Directed Attendant Care (CDAC) - skilled |
| Other Service | Consumer Directed Attendant Care (CDAC) - unskilled |
| Other Service | Home and Vehicle Modification |
| Other Service | Interim Medical Monitoring and Treatment |
| Other Service | Personal Emergency Response or Portable Locator System |
| Other Service | Supported Community Living |
| Other Service | Transportation |

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Adult Day Health

**Alternate Service Title (if any):**

Adult Day Care

**HCBS Taxonomy:**

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

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

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

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

**Service Definition** *(Scope):*
Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on regular or intermittent basis in a day care center. Supports provided during day care would be ADLs and IADLs. Included are personal cares (ie: ambulation, toileting, feeding, medications) or intermittent health-related cares, not otherwise paid under other waiver or state plan programs.

Meals provided as part of these services shall not constitute a full nutritional day; each meal is to provide 1/3 of daily dietary allowances.

Transportation is not a required element of adult day services but if the cost of transportation is provided and charged to Medicaid, the cost of transportation must be included in the adult day health per diem.

Adult day care does not cover therapies: OT, PT or speech.
**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).

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Adult Day Care Agencies |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Adult Day Care**

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

**Certificate** *(specify):*
Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 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:**
The 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:**
Day Habilitation

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

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

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

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

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

**Service Definition** *(Scope):*
Day Habilitation means Provision of regularly scheduled activities such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the participant's person-centered plan. Day habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's person-centered services and supports plan, such as physical, occupational, or speech therapy.

Day habilitation services are not limited to fixed-site facilities. Day habilitation may be furnished in a variety of settings in the community other than the person's private residence. For members living in a residential care facility, Day Hab services provided in the facility are not considered to be provided in the member's home. Services provided in a residential care facility setting must be provided separate from the participant's private residence or other residential living arrangements.

When transportation is provided between the participants' place of residence and the Day Habilitation service site(s) and is provided as a component part of this service, the cost of transportation is included in the rate paid to providers of day habilitation services.

Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. Transportation provided to and from a member's place of residence is not a required component of Day Habilitation.

The first line of prevention of duplicative billing for similar types of day programs (Day Habilitation, pre-vocational, supported employment and Adult day care) is the member's case manager. The case manager is responsible for the authorization and monitoring of services in a member's plan of care. If the case manager authorizes similar services during the same time period, they are responsible to assure that the services are being delivered as authorized. The ISIS system generates a review report to assist the case manager. The report identifies all services that have been billed for a specific time period (ex. one month). The case manager is able to view the service billed to the individual member, the amount of the service billed and the provider. The case manager is able to compare what has been billed by the provider to what is ordered in the plan of care. The department also conducts post audit reviews of providers to review the billing of providers to assure that the services provided have documentation to support the billing.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service may be a 15- minute unit or a full day (4.25 to 8 hours). For the family training option, a unit of service is a 15 minute unit. The units of family training option services are limited to a maximum of 40, 15-minute units per month. Services may be provided in any community based setting, but not be provided in the member's home, except when providing the family training component of day habilitation.
Meals provided as part of this service shall not constitute a full nutritional regimen of 3 meals per day.
Transportation provided to and from a member's place of residence is not a required component of Day Habilitation.
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.

**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 |
|---|---|
| | |

| Provider Category | Provider Type Title |
|---|---|
| Agency | CQL Accredited |
| Agency | CARF Accredited |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Day Habilitation**

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

**Certificate** *(specify):*

**Other Standard** *(specify):*
Agencies accredited by the Council on Quality and Leadership.
**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: Day Habilitation**

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

**Certificate** *(specify):*

**Other Standard** *(specify):*
Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation pursuant to Iowa Administrative Code 441- 78.41(14),
**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:**
Prevocational Services

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

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

**Service Definition** *(Scope):*

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

Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

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

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially based informed choice regarding the goal of individual employment. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local

community or nearby communities and may include but is not limited to the following activities:
1. Meeting with the member, and their family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences
2. business tours,
3. informational interviews,
4. job shadows,
5. benefits education and financial literacy,
6. assistive technology assessment, and
7. other job exploration events.
(2) Expected outcome of service.
1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
2.The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.
b. Setting. Prevocational services shall take place in community-based nonresidential settings.
c. Concurrent services. A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same

Transportation provided as a component of prevocational services and the cost of transportation is included in the rate paid to providers of prevocational services.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is one hour.

Exclusions. Prevocational services payment shall not be made for the following:
(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.
(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
(3) Compensation to members for participating in prevocational services.
(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g. hospitals, nursing homes), and support for members volunteering to benefit the service provider is prohibited.
(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.
(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

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

1. The member who is in Prevocational Services is also working in either individual or small group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or
2. The member who is in Prevocational Services is also working in either individual or small group community employment for less than the number of hours per week the member wants, as identified in the member's current service plan, but the member has services documented in his/her current service plan, or through another

identifiable funding source (e.g. IVRS), to increase the number of hours the member is working in either individual or small group community employment; or
3. The member is actively engaged in seeking individual or small group community employment or individual self-employment, and services for this are included in his/her current service plan, or services funded through another identifiable funding source (e.g. IVRS) are documented in the member's service plan; or
4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months and has been denied and/or placed on a waiting list by both Medicaid and IVRS; or
5. The member has been receiving Individual Supported Employment service (or comparable services available through IVRS) for at least 18 months without obtaining seeking individual or small group community employment or individual self-employment.
6. The member is participating in career exploration activities

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan This time limit can be extended as stated in paragraphs "1" through "6." If the criteria in paragraphs 1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | CQL Accredited |
| Agency | CARF Accredited |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Prevocational Services**

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

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Providers accredited by the Council on Quality and Leadership.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.
(2) A person providing direct support shall not be an immediate family member of the member.
(3) A person providing direct support shall, within 6 months of hire or within 6 months of [the effective date of this subrule], complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs.
(4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

**Verification of Provider Qualifications**

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

**Frequency of Verification:**
Every four year

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Prevocational Services**

**Provider Category:**
Agency

**Provider Type:**
CARF Accredited

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Accredited by the Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

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

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.
(2) A person providing direct support shall not be an immediate family member of the member.
(3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs.
(4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

**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:**
Residential Habilitation

**Alternate Service Title (if any):**
Residential Based Supported Community Living

**HCBS Taxonomy:**

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

**Service Definition** *(Scope)*:
Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.
a. Allowable service components are the following:
(1) Daily living skills development. These are services to develop the child's ability to function independently in

the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.
(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.
(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and
that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.
4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child,
including interventions to ameliorate problem behaviors.
b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.
c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.
d. Room and board costs are not reimbursable as residential-based supported community living services.
e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)"d."
f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program

Transportation services may be provided for consumers to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. Transportation to and from school are not reimbursable under the RBSCL service
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is a day. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

**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 | Foster care |
| Agency | RCF/ID |
| Individual | Certified Residential Based Supported Community Living Providers |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Residential Based Supported Community Living**

**Provider Category:**

Agency

**Provider Type:**
Foster care
**Provider Qualifications**
**License** *(specify):*
Agencies licensed by the department as group living foster care facilities under Iowa Administrative Code 441—Chapter 114.
**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: Statutory Service**
**Service Name: Residential Based Supported Community Living**

**Provider Category:**
Agency
**Provider Type:**
RCF/ID
**Provider Qualifications**
**License** *(specify):*
Agencies licensed by the department as residential facilities for intellectually disabled children under Iowa Administrative Code 441—Chapter 116.
**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: Statutory Service**
**Service Name: Residential Based Supported Community Living**

**Provider Category:**
Individual

**Provider Type:**
Certified Residential Based Supported Community Living Providers
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
Providers certified by the HCBS Quality Oversight Unit to provide Residential Based Supported Community Living pursuant to Iowa Administrative Code 441 - 77.37.
**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:**
Statutory Service
**Service:**
Respite
**Alternate Service Title (if any):**

**HCBS Taxonomy:**

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

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

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

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

**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 case manager who manages all services and the entry into the ISIS system. The case manager 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. ID 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. Payment for respite services shall not exceed $7,262 per the member's waiver year.
d. The service shall be identified in the member's individual comprehensive plan.
e. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS ID waiver supported community living services, Medicaid or HCBS ID nursing, or Medicaid or HCBS ID home health aide services.
f. 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.
g. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441-83.60(249A).
h. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
i. 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.

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.

**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 | Nursing facilities, intermediate care facilities for the intellectually disabled, and hospitals |
| Agency | RCF/ID |
| Agency | Home Health Agency |
| Agency | Camps |
| Individual | Respite care providers certified under the Intellectual Disability or Brain Injury waivers. |
| Agency | Foster Care |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Agency
**Provider Type:**
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
**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 consumer'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:**
RCF/ID
**Provider Qualifications**

**License** *(specify):*
Residential care facilities for persons with intellectual disabilities licensed by the department of inspections and appeals.
**Certificate** *(specify):*

**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 consumer'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 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:**
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):*
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 consumer'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:**
Camps

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
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 consumer'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:**

Individual

**Provider Type:**

Respite care providers certified under the Intellectual Disability or Brain Injury waivers.

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Respite care providers certified by the department HCBS Quality Oversight Unit under the Intellectual Disability or Brain Injury waivers as part of Iowa Administratvie Code 447-77.37 and 77.39.

**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 consumer'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:**
Foster Care

**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):*
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 consumer'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: Service Specification

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

**Service Type:**
Statutory Service
**Service:**
Supported Employment
**Alternate Service Title (if any):**
Supported Employment

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 03 Supported Employment | 03021 ongoing supported employment, individual |
| **Category 2:** | **Sub-Category 2:** |
| 03 Supported Employment | 03010 job development |
| **Category 3:** | **Sub-Category 3:** |
| 03 Supported Employment | 03030 career planning |
| **Category 4:** | **Sub-Category 4:** |
| 03 Supported Employment | 03022 ongoing supported employment, group |

**Service Definition** *(Scope):*

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

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

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

Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.
Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:
1. Benefits education
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to
customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing
employer).
13. Re-employment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on the job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.

Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home- based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed assistance to establish self-employment may include:
1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance
in developing and launching a business.
3. Identification of the long-term supports necessary for the individual to operate the business.

Long-term job coaching. Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.
Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

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

Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized and service plan are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:
1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage
and benefits).
12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member
to be successful in integrating into the job setting.
13. Transportation of the member during service hours.
14. Career exploration services leading to increased hours or career advancement.

Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10)"b"(4), assistance to maintain self-employment may include:
1. Ongoing identification of the supports necessary for the individual to operate the business;
2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
3. Ongoing benefits education and support.

The hours of support tier assignment for long-term job coaching is based on the identified needs of the member as documented in the member's comprehensive service plan and adjusted when higher support needs are determined.

Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and

planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration, or development of strengths and skills that contribute to successful participation in individual community employment.

Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

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

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

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service for Individual Supported Employment is 15 minutes
A unit of service for Small group Employment is 15 minutes
A unit of service for Long-Term Job Coaching is a monthly unit of service. The hours of support tier assignment for long-term job coaching is based on the identified needs of the member as documented in the member's comprehensive service plan and adjusted when higher support needs are determined based on the hours of support the member requires each month.

Service requirements for all supported employment
(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.
(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.
(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.
(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential

services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).
(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.
(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

Limitations. Supported employment services are limited as follows:
(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.
(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed $3,029.00 per month.
(3) Individual supported employment is limited to 240 units per calendar year.
(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

Exclusions. Supported employment services payments shall not be made for the following:
(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals
with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these
programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.
(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation
in a supported employment program.
(3) Subsidies or payments that are passed through to users of supported employment programs.
(4) Training that is not directly related to a member's supported employment program.
(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other
similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.
(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training
activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration
activities.
(7) Tuition for education or vocational training.
(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.
(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

For member's choosing the Consumer Choices Option, 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.

**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 | CQL Accredited |
| Agency | ICCD Accredited |
| Agency | CAFC Accredited |
| Agency | Joint Accredited |
| Agency | CARF Accredited |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Supported Employment**

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

**Certificate** *(specify):*

**Other Standard** *(specify):*
An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.
(2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.

(3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 04, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

**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: Supported Employment**

**Provider Category:**

Agency

**Provider Type:**

ICCD Accredited

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

An agency that is accredited by the International Center for Clubhouse Development.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.
(2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also

hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
(3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 04, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

**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: Supported Employment**

**Provider Category:**
Agency
**Provider Type:**
CAFC Accredited
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
(3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 04, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching
(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

**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: Supported Employment**

**Provider Category:**
Agency
**Provider Type:**
Joint Accredited
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements

outlined in administrative rule:
(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.
(2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
(3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 04, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching
(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

**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: Supported Employment**

**Provider Category:**
Agency

**Provider Type:**
CARF Accredited

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service.

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers' compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

Individuals may not provide supported employment services except when the services are purchased

through the consumer choices option.

Direct support staff providing individual or small group supported employment or long term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or CESP or similar) as an employment specialist or must earn this credential within 24 months of hire.
(2) Long-term job coaching: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, a nationally recognized certification in job training and coaching.
(3) Small-group supported employment: associate degree, or high school diploma or equivalent and six months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 04, 2016 complete at least 9.5 hours of employment services training as offered through Direct Course or courses from ACRE certified training programs. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching
(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

**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 Servies

**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 are 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). 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 specified 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 member with bath, shampoo, or oral hygiene.
(3) Helping a member with toileting.
(4) Helping a member in and out of bed and with ambulation.
(5) Helping a member 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 member's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

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 state plan and waiver services is avoided by the use of a case manager who manages all services and the entry of the service plan into the ISIS system. The case manager 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 shall include unskilled medical services and shall exceed those services provided under HCBS ID waiver supported community living or the Medicaid state plan home health aide benefit. Instruction, supervision, support or assistance in personal hygiene,
bathing, and daily living shall be provided under supported community living.
a. Services shall be included in the consumer'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 Servies**

**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 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 consumers 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 case manager who manages all services and the entry into the ISIS system. The case manager 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 service plan will show how the consumer health care needs are being met. Services must be authorized in the service plan. The Iowa Dept. of Human Services' case manager will monitor the plan.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | 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 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) 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 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**
- ☑ **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 |

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

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

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
This service is necessary for members who choose the self-direction option at a maximum of 30 hours a year. When a member first initiates the self-direction option, the Independent Support Broker will be required to meet with the member at least monthly for the first three months and quarterly after that. If a member needs additional support brokerage service, the member will need prior authorization from the state. There will be a maximum rate per hour limit.

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

- [x] **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 and Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

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

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):**

Individual Directed Goods and Services

**HCBS Taxonomy:**

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

**Service Definition** *(Scope):*

Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

Participants (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their case manager and ISB to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.

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

Individual directed goods and services must be documented on the individual budget. The individual budget limit will be based on the service plan and the need for the services available to be converted. A utilization adjustment rate is applied to the individual budget amount. Please see Section E- 2- b ii for details on how the CCO budget is created.

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

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

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

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

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

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individuals or buisnesses |

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**
**Service Name: Individual Directed Goods and Services**

**Provider Category:**
Individual
**Provider Type:**
Individuals or buisnesses
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify):*

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
The member, the independent support broker and the financial management service.

**Frequency of Verification:**
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 case manager. 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.

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

The following are examples of supports a member can purchase to help the member live and work in the community:
o Career counseling
o Career preparation skills development
o Cleaning skills development
o Cooking skills development
o Grooming skills development
o Job hunting and career placement
o Personal and home skills development
o Safety and emergency preparedness skills development
o Self-direction and self-advocacy skills development
o Social skills development training
o Supports to attend social activities
o Supports to maintain a job
o Time and money management
o Training on use of medical equipment
o Utilization of public transportation skills development
o Work place personal assistance

Participants (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their case manager and ISB to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Community support and employment services must be identified on the individual budget plan. The individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget. The ID waiver allows for the following eight ID waiver services to be converted to create a CCO budget:
1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.
A utilization adjustment rate is applied to the individual budget amount. Please see Section E- 2- b ii for details on how the CCO budget is created. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services.

**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)*:

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individual or business |

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**
**Service Name: Self Directed Community Support and Employment**

**Provider Category:**
Individual

**Provider Type:**
Individual or business

**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 Have current liability and workers' compensation coverage as required by law.

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.
d. 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 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:**

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 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 that they would normally do themselves if they did not have a disability; activities of daily living and incidental activities of daily living that help the person remaining the home and in their community. This assistance may take the form of hands-on assistance (actually performing a task for a person) or cuing to prompt the participant to perform a task. Personal care may be provided on an episodic or on a continuing basis.

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

Participants (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their case manager and ISB to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.

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

Self-directed personal care services need to be identified on the individual budget plan. The individual budget limit will be based on the service plan and the need for the services available to be converted. A utilization adjustment rate will be applied to the individual budget amount. Transportation costs within this service is billed

separately and not included in the scope of personal care. Please see Section E-2- b ii. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services.

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

- [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 business |

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**
**Service Name: Self Directed Personal Care**

**Provider Category:**
Individual

**Provider Type:**
Individual or business

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
The member, 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 (CDAC) - 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.

Skilled CDAC service is not duplicative of HHA or nursing. The case manager through the service plan authorization specifies the services and providers to provide waiver services and precludes duplication of services.

Covered skilled service activities:
(1) Tube feedings of members unable to eat solid foods.
(2) Intravenous therapy administered by a registered nurse.
(3) Parenteral injections required more than once a week.
(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, re-motivation,and behavior modification.
(8) Colostomy care.
(9) Care of out of control medical conditions which includes brittle diabetes, and comfort care of terminal

conditions.
(10) Post-surgical nursing care.
(11) Monitoring medications 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.
**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 case manager will monitor the plan.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home Health Agency |
| Agency | Community Action Agency |
| Agency | AAA subtracting Chore Providers |
| Agency | Home Care Provider |
| Individual | Any individual who contracts with the member |
| Agency | Supported Community Living Providers |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Consumer Directed Attendant Care (CDAC) - 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 (CDAC) - skilled**

**Provider Category:**
Agency
**Provider Type:**
Community Action Agency
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Community action agencies as designated in Iowa Code section 216A.93.
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. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers 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 (CDAC) - skilled**

**Provider Category:**
Agency
**Provider Type:**
AAA subtracting Chore Providers
**Provider Qualifications**
**License** *(specify):*
**Certificate** *(specify):*
**Other Standard** *(specify):*
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. Case managers 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 (CDAC) - skilled**

**Provider Category:**
Agency
**Provider Type:**
Home Care Provider
**Provider Qualifications**
**License** *(specify):*
**Certificate** *(specify):*
**Other Standard** *(specify):*
Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in Iowa Administrative Code 641—80.5(135), 641—80.6(135), and 641—80.7(135).
**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: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer Directed Attendant Care (CDAC) - 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. Case managers 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 (CDAC) - 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 Service, 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 (CDAC) - 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. This service is not duplicative of Home Health Aide or Homemaker services; and is monitored by the case 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 devises 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 case manager will monitor the 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.

**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 | Supported Community Living Providers |
| Agency | Community Action Agency |
| Agency | Assisted Living Programs |
| Agency | Home Health Agency |
| Agency | AAA subtracting Chore Providers |
| Individual | Any individual who contracts with the member |
| Agency | Adult Day Care |
| Agency | Home Care Providers |

## Appendix C: Participant Services

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

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

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

**Certificate** *(specify):*

**Other Standard** *(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.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Service, 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 (CDAC) - unskilled**

**Provider Category:**
Agency

**Provider Type:**
Community Action Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Community action agencies as designated in Iowa Code section 216A.93.
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. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers 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 (CDAC) - 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 481—Chapter 69.

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. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**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 (CDAC) - 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 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 (CDAC) - unskilled**

**Provider Category:**

Agency

**Provider Type:**

AAA subtracting Chore Providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

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. Case managers 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 (CDAC) - 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. Case managers 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 (CDAC) - unskilled**

**Provider Category:**
Agency

**Provider Type:**
Adult Day Care

**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: Provider Specifications for Service

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

**Provider Category:**
Agency

**Provider Type:**
Home Care Providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

**Verification of Provider Qualifications**

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

**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 ID waiver is limited to a $5,305.53 lifetime maximum. 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 case manager.

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.

**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 | Supported Community Living Providers |
| Agency | Community Business |
| Agency | HVM Providers Enrolled under Other Waivers |

## 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:**
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 Service, 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):*
**Certificate** *(specify):*
**Other Standard** *(specify):*
Submit verification of current liability and workers compensation coverage.
**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:**
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:**
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:**
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 one-hour units 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 a 15 minute unit.

**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 | Supported Community Living providers |
| Agency | child care facility |
| Agency | Home Health Agency |

## 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):*

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

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Interim Medical Monitoring and Treatment**

**Provider Category:**
Agency
**Provider Type:**
child care facility
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
department of Humans Services Iowa Medicaid Enterprise
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Interim Medical Monitoring and Treatment**

**Provider Category:**
Agency

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

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

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

## Appendix C: Participant Services

### C-1/C-3: 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 or Portable Locator System

**HCBS Taxonomy:**

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

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

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

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

**Service Definition** *(Scope):*
A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency. The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | 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 or Portable Locator System**

**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:**
Supported Community Living

**HCBS Taxonomy:**

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

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

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

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

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

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

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

Community skills training services means activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:
1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget; plan and prepare nutritional meals; ability to use community resources such as public transportation, libraries, etc., and ability to select foods at the grocery store.
2. Socialization skills training services are those activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.
3. Communication skills training services are activities which assist a person to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

Personal and environmental support services means activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

Transportation services means activities and expenditures designed to assist the person to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from medical services. Members needing transportation to and from medical services must use the state plan medical transportation services.

Treatment services means activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.
1. Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.
2. Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person's functioning in response to the physical, emotional, and social environment.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is:
(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for 8 or more hours per day as an average over a 30 days and the member's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision. The cost per unit is capped at the average ICF/ID rate calculated retrospectively each year.
(2) 15 minute units when subparagraph (1) does not apply. 15 minute unit reimbursement amounts cannot exceed the fee schedule caps published in the Iowa Administrative Code 441 - 77.79(1).

For daily unit reimbursement, the provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The cost of transportation may be included in the rate of the services as allowed by rule. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per member per year, and the provider must maintain records to support the expenditures.

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

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.

**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 | Foster Family Home Subcontractors |
| Agency | Licensed Foster Care |
| Agency | Certified Supported Community Living Providers |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Supported Community Living**

**Provider Category:**
Agency

**Provider Type:**
Foster Family Home Subcontractors

**Provider Qualifications**

**License** *(specify)*:
Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

**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: Supported Community Living**

**Provider Category:**
Agency

**Provider Type:**
Licensed Foster Care

**Provider Qualifications**

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

**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: Supported Community Living**

**Provider Category:**
Agency

**Provider Type:**
Certified Supported Community Living Providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
Providers certified by the HCBS Quality Oversight Unit to provide Supported Community Living pursuant to Iowa Administrative Code 441 - 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: Service Specification

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

**HCBS Taxonomy:**

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

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

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

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

**Service Definition** *(Scope):*
Transportation services may be provided for members to conduct business errands, essential shopping, and to reduce social isolation. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized. This service does not include transportation to medical services.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of services is one mile or one one-way trip. The member's service plan will show how the member's health care needs are being met. Services must be authorized in the service plan. The case manager will monitor the 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.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Provider Contracting with NEMT |
| Agency | Supported Community Living Providers |
| Agency | Commuity Action Agency |
| Agency | Subcontactor with Area Agency on Aging |
| Agency | County Contracted Transportation Provider |
| Agency | Area Agencies on Aging |
| Agency | Regional Transit Agencies |
| Agency | Nursing Facilities |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**
Agency
**Provider Type:**
Provider Contracting with NEMT
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Transportation providers contracting with the nonemergency medical transportation contractor.
**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: Transportation**

**Provider Category:**
Agency
**Provider Type:**
Supported Community Living Providers
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Providers certified by the HCBS Quality Oversight Unit to provide supported community living under the ID and BI Waiver pursuant to Iowa Administrative Code 441 - 77.37 and 77.39.

**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: Transportation**

**Provider Category:**
Agency

**Provider Type:**
Commuity Action Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa 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: Transportation**

**Provider Category:**
Agency

**Provider Type:**
Subcontactor with Area Agency on Aging

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
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: Transportation**

**Provider Category:**
Agency

**Provider Type:**
County Contracted Transportation Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Transportation providers that contract with county governments.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
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: Transportation**

**Provider Category:**
Agency

**Provider Type:**
Area Agencies on Aging

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Area Agencies on Aging as designated by the Department on Aging in 17—4.4(231).

**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: Transportation**

**Provider Category:**
Agency

**Provider Type:**
Regional Transit Agencies

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
As designated by the Iowa Department of Transportation in the Code of Iowa 28M.
28M.1 Regional transit district defined.
"Regional transit district" means a public transit district created by agreement pursuant to chapter 28E by one or more counties and participating cities to provide support for transportation of passengers by one or more public transit systems which may be designated as a public transit system under chapter 324A.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education beyond those implemented by the contracting agency or provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers 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: Transportation**

**Provider Category:**
Agency
**Provider Type:**
Nursing Facilities
**Provider Qualifications**
**License** *(specify):*
Licensed and inspected under Iowa Code Chapter 135C and an enrolled Medicaid provider 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: 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 provide case management services to fee-for-service participants enrolled in the State's §1915 (c) PD, HD, ID, and Aids Waivers. DHS 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.

Targeted case management (TCM) may be provided to ID waiver participants by four different provider types. The individual counties within the state establish contracts for providing targeted case management within the county. The TCM provider options include TCM provided by: (1) Department of Human Services; (2) County Case Management; (3) private case management entities; or (4) providers that are accredited for case management by national accrediting bodies (e.g., CARF). All TCM units are required to be accredited by the state of Iowa Mental Health and Disabilities Services for 441 Iowa Administrative Code Chapter 24 case management services.

## Appendix C: Participant Services

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

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

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

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

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

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 [(Department of Human Services)] 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. Background checks only include Iowa unless the applicant is a resident of another state providing services in Iowa.

MCOs are contractually required to assure that all persons, whether they are employees, agents, subcontractors, or anyone acting for or on behalf of the MCO, are properly licensed, certified, or accredited as required under applicable state law and the Iowa Administrative Code. The Contractor shall provide standards for service providers who are not otherwise licensed, certified, or accredited under state law or the Iowa Administrative Code.

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.

The Iowa Department of Human Services maintains the Central Abuse Registry. 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.*

A person who is legally responsible for a participant may provide services to a waiver participant. This applies to guardians of their adult children and not to a minor child. The person who is legally responsible for a participant may be a Consumer Directed Attendant Care (CDAC) provider or an employee under the Consumer Choices Option (CCO) program. There are no limitations on the types of services provided; however, when the legally responsible person is the CDAC or CCO provider, the service planning team determines the need for and the types of activities to be provided by the legally responsible person. This includes reviewing if the needed services are "extraordinary." Any services which are activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and are not necessary to assure the health and welfare of the participant and to avoid institutionalization would not be considered extraordinary. If the legal representative is an employee through CDAC or CCO, the relative or legal guardian must have the skills needed to provide the services to the participant. In many situations, the participant requests the guardian to 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.

Through the person-centered planning process, the comprehensive service plan is developed. If the participant has a guardian or attorney in fact under a durable power of attorney for health care who is also their service provider, the care plan will address how the service worker, case manager, health home coordinator, or community-based case manager will oversee the service provision to ensure care is delivered in the best interest of the participant.

The rate of pay and the care provided by the legally responsible person is identified and authorized in the participant's plan of care that is authorized and monitored by a service worker/case manager/health home coordinator/community-based case manager. Service plans are monitored to assure that authorized services are received. For fee-for-service participants, the State completes post utilization audits on waiver providers verifying that services rendered match the service plan and claim process. This applies to individual CDAC providers. In addition, information on paid claims for fee-for-service participants are available in ISIS for

review. The ISIS system compares the submitted claims to the services authorized in the plan of care prior to payment. The claim will not be paid if there is a discrepancy between the amount billed and the rate of pay authorized in the plan. MCOs are responsible for ensuring the provision of services by a legally responsible individual is in the best interest of the member and that payments are made only for services rendered. All representatives must participate in a training program prior to assuming self-direction, and MCOs provide ongoing training upon request and/or if it is determined a representative needs additional training. MCOs monitor the quality of service delivery and the health, safety and welfare of members participating in self-direction, including implementation of the back-up plan. If problems are identified, a self-assessment is completed to determine what additional supports, if any, could be made available. MCOs must ensure payments are made only for services rendered through the development and implementation of a contractually required program integrity plan. The DHS maintains oversight of the MCO program integrity plans and responsibility for overall quality monitoring and oversight.

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."

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 managemt) 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 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: |

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

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| | |

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

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

| 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<br>Confidence Interval = |
| ☑ Other<br>Specify:<br>Contracted entity including MCO | ☐ Annually | ☐ Stratified<br>Describe Group: |
| | ☑ Continuously and Ongoing | ☐ Other<br>Specify: |
| | ☐ Other<br>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<br>Specify: | ☐ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>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** |
| ☐ **Other** | ☐ **Annually** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| Specify: | |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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**<br>Specify:<br>MCO | ☐ **Annually** |

| Responsible Party*(check each that applies):* | Frequency of data aggregation and analysis *(check each that applies):* |
|---|---|
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>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.*

## 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 are referenced in Attachment #2 HCB Settings. CMS is reviewing the statewide transition plan.