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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

There have been three amendments approved by CMS to the AIDS/HIV waiver since July 1, 2015:

1. April 1, 2016: Implementation of managed care.

2. May 4, 2016 the Department implemented the use of the InterRAI standardized assessment tool for the purposes of level of care determination and service planning for the HCBS AIDS/HIV waiver.

3. October 1, 2018: Implement new performance measures. Reduced the number of performance measures from 44 to 22.

With this renewal application the following changes are being made:

The role of the DHS Social Worker is removed in the AIDS/HIV Waiver. With the implementation of managed care April 1, 2016, the Department restructured personnel and the DHS Social Worker was removed from an active role within the AIDS/HIV Waiver.

Adds three (3) new performance measures in Appendix C (Qualified Providers). Added performance measures QP-a2, QP-b2,and QP-b3

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Home and Community Based Services - AIDS/HIV

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IA.0213
Draft ID: IA.015.06.00

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

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

07/01/20

1. Request Information (2 of 3)

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

☒ **Hospital**

Select applicable level of care

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

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

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

☒ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

previously approved:

1915(b)Iowa High Quality Healthcare Initiative was previously approved on February 24, 2016, with an effective date of April 1, 2016

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

- ☒ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☒ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☒ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

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

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

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

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

Services include Adult day care, Homemaker, Respite, Home Health Aide, Nursing, Consumer Directed Attendant Care, Counseling, Home Delivered Meals, and self-directed services. Self-directed services include financial management services, independent support broker, self-directed personal care, self-directed community and employment support, and individual directed goods and services.

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

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are

provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,

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

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the

participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

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

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

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

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

I. Public Input. Describe how the state secures public input into the development of the waiver:

DHS seeks continuous and ongoing public input through a variety of committees and organizations. Specifically, the Mental Health Planning Council meets monthly and provides input as necessary. DHS has appointed one staff person from the IME Long Term Care Unit to the Council, which includes various stakeholders including participants and families, providers, case managers, and other State departments. IME is also invited to attend a number of association and advocacy group meetings (i.e., Iowa Association of Community Providers, Iowa State Association of Counties, Iowa Health Care Association, and Olmstead Task Force) to provide and seek feedback on service planning, cost reporting, quality assurance documentation requirements, and case management issues.

The public has the opportunity to comment on Iowa Administrative rules and rule changes through the public comment process, the Legislative Rules Committee, and the DHS Council. The IME also provides notice of applications and amendments by including notice in the IME e-News emails and on the IME website.

IME used the following processes to secure public input into the development of the waiver renewal:

1) IME Website Posting - The public notice and the Waiver amendment was posted to the DHS IME Website under the category, News & Initiatives (https://dhs.iow.gov/public-notices/AIDS-HIV-amendments). The public posting period began December 12, 2019 and ended January 12, 2020.

2) DHS Field Office Posting - IME provides notification to the DHS Field Office, which in turn, notifies each DHS Field Office to post the Waiver Public Notice and to provide a copy of the CMS Waiver Amendment for any public request. The public posting period began December 12, 2019 and ended January 12, 2020.

3) IME Public Notice Subscribers - Medicaid members, Medicaid providers, legislators, advocacy organizations and others who wish to remain informed regarding Iowa Medicaid can subscribe to the IME Public Notice webpage. All subscribers will receive electronic notice whenever an update/public notice is posted. The public posting period began December 12, 2019 and ended January 12, 2020.

4) Iowa Tribal Nations Notification - The IME Tribal Nations liaison notified all Nation governments by phone on December 12, 2019 and via email on December 12, 2019. Both notifications indicated a 30 day comment period. The comment period ended on January 12, 2020.

The AIDS/HIV was posted for public comment as identified above from December 12, 2019 through January 12, 2020 Public comments received and the state's response will be added to the renewal application after the public comments period ends:

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

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

7. Contact Person(s)

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

Last Name:

Wines

First Name:

Brian

Title:

Program Manager

Agency:

Iowa Department of Human Services/Iowa Medicaid Enterprise

Address:

611 5th Street

Address 2:

City:

Des Moines

State: **Iowa**

Zip:

50309

Phone:

(515) 256-4661 **Ext:** ☐ **TTY**

Fax:

(515) 725-1360

E-mail:

bwines@dhs.state.ia.us

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

Last Name:

Steenblock

First Name:

Jennifier

Title:

Federal Compliance Officer

Agency:

Iowa Department of Human Services/Iowa Medicaid Enterprise

Address:

611 5th Street

Address 2:

City:

Des Moines

State: **Iowa**

Zip:

50309

Phone:

(515) 256-4636 **Ext:** ☐ **TTY**

Fax:

(515) 725-1360

E-mail:

Jsteenb@dhs.state.ia.us

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

Randol

First Name:

Michael

Title:

Medicaid Director

Agency:

Iowa Department of Human Services/Iowa Medicaid Enterprise

Address:

611 5th Street

Address 2:

City:

Des Moines

State: **Iowa**

Zip:

50309

Phone:

(515) 256-4621 **Ext:** ☐ **TTY**

Fax:

(515) 725-1360

E-mail:

mrandol@dhs.state.ia.us

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

◉ **The waiver is operated by the state Medicaid agency.**

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

◉ **The Medical Assistance Unit.**

Specify the unit name:

Bureau of Long Term Care, Iowa Medicaid Enterprise

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

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

(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver

operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

MCOs will generally be responsible for delivering covered benefits, including physical health, behavioral health and LTSS in a highly coordinated manner. Specific functions include, but are not limited to, the following:

- Developing policies and procedures for ongoing identification of members who may be eligible for waiver services;
- Conducting comprehensive needs assessments, developing service plans, coordinating care, and authorizing and initiating waiver services for all members;
- Conducting level of care reassessments with IME retaining final review and approval authority for any reassessments which indicate a change in the level of care;
- Delivering community-based case management services and monitoring receipt of services;
- Contracting with an entity or entities for financial management services to assist members who elect self-direction (i.e., Iowa's "Consumer Choices Option");
- Maintaining a toll-free telephone hotline for all providers with questions, concerns, or complaints;
- Maintaining a toll-free telephone hotline for all members to address questions, concerns, or complaints;
- Operating a 24/7 toll-free Nurse Call Line which provides nurse triage telephone services for members to receive medical advice from trained medical professionals;
- Creating and distributing member and provider materials (handbooks, directory, forms, policies and procedures, notices, etc.);
- Operating an incident reporting and management system;
- Maintaining a utilization management program;
- Developing programs and participating in activities to enhance the general health and well-being of members; and
- Conducting provider services such as network contracting, credentialing, enrollment and disenrollment, training, and claims processing.

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

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

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

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

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

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

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

Revenue Collections Unit (HMS), as part of a contract with the IME, performs recovery of identified overpayments related to program integrity efforts, cost report reconciliations, third-party liability, and trusts.

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

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

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the

state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Iowa Department of Human Services, IME Medical Enterprise staff, are responsible for oversight of the contracted entities. The DHS IME is the State Agency responsible for conducting the operational and administrative functions of the waiver.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

IME is an endeavor that unites State Staff and "Best of Breed" contractors into a performance-based model for the administration of the Iowa Medicaid program. The IME is a collection of specific units, each having an area of expertise, and all working together to accomplish the goals of the Medicaid program. Housed in a single building, the IME has contract staff who participates in the following activities: provider services, member services, provider audit and rate setting, processing payments and claims, medical services, pharmacy, program integrity, and revenue collections. All contracts are selected through a competitive request for proposal (RFP) process. Contract RFPs are issued every five years.

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

The State has established a MCO Oversight and Supports Bureau within IME to provide comprehensive program oversight and compliance. Specifically, a Bureau Chief, reporting directly to the Medicaid Director, is responsible for directing the activities of two MCO account managers, two quality improvement outcome oversight staff, one encounter data specialist, one actuarial rate setting specialist, and three MCO member/provider analysts. Each MCO account manager is paired with an MCO member/provider analyst to oversee contract compliance for one designated MCO. The MCO account managers serves as liaisons between the MCOs and the State, and is the point of contact coordinating communications and connecting subject matter experts. The MCO Bureau works directly with the IME Program Integrity Unit, which oversees compliance of all IME providers, including the MCOs. In addition to the MCO Bureau, the IME has two additional contract oversight staff for managed care related vendors, a business analyst, a data analyst, a communications specialist, and an additional program integrity specialist.

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☒

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
AA-2: The IME shall measure the number and percent of months in a calendar quarter that each MCO reported all HCBS PM data measures. Numerator = # of months each MCO entered all required HCBS PM data; Denominator = # of reportable HCBS PM months in a calendar quarter.

Data Source (Select one):
Other
If 'Other' is selected, specify:

MCO performance monitoring

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

Data Aggregation and Analysis:

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

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

Performance Measure:
AA-1: IME shall measure the number and percent of required MCO HCBS PM quarterly reports that are submitted timely. Numerator = # of HCBS PM quarterly reports submitted timely; Denominator = # of MCO HCBS PM quarterly reports due in a calendar quarter.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO performance monitorin

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Through the Bureau of Managed Care each MCO is assigned state staff as the contract manager; and other state staff are assigned to aggregate and analyze MCO data. This staff oversees the quality and timeliness of monthly reporting requirements. Whenever data is late or missing the issues are immediately addressed by each MCO account manager to the respective MCO.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

If the contract manager, or policy staff as a whole, discovers and documents a repeated deficiency in performance of the MCO, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of payment compensation.

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☒	**HIV/AIDS**	0		☒
	☐	**Medically Fragile**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Per 441 Iowa Administrative Code 83.42(1) individuals must be diagnosed by a physician as having AIDS or HIV infection.

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

◉ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	35
Year 2	36
Year 3	37
Year 4	38
Year 5	39

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

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

waiver:

Individuals are accepted into the AIDS/HIV waiver on a first come first served basis based on the date of application.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- ( ) **No**
- (●) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

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

  Specify percentage:
- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

Parents and other caretaker relatives specified at 42 CFR §435.110; pregnant women specified at 42 CFR §435.116; and children specified at 42 CFR §435.118.

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

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

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

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

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

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

Specify dollar amount:

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

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

○ **The following standard included under the state plan**

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

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

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

Specify:

◉ **Other**

Specify:

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

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

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

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

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

Specify:

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

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

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

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

Specify:

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

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

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

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

Specify:

- ( ) **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

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

Specify formula:

◉ **Other**

Specify:

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

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

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

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

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

As part of the AIDS/HIV waiver service, case management is required for each participant, regardless of delivery system. Case managers and community-based case managers are required to make monthly contacts, either face to face or telephonic, regarding each member in order to establish access to services and to ensure the authorized services are provided as outlined in the participant's service plan to ensure the participant's health, safety and welfare. Case managersand community-based case managers are additionally required to make face-to-face contact with the member once per quarter.

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

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

Specify the entity:

- ◉ **Other**

Specify:

The Iowa Medicaid Enterprise (IME) Medical Services Unit (MSU) is responsible for making all initial level of care decisions. If a member is not currently on Medicaid or is in Medicaid fee-for-service (FFS), the IME's Core Standardized Assessment (CSA) contractor performs the assessment. If a member is enrolled with a MCO, the initial assessment is performed by the MCO, but the IME Medical Services unit conducts the initial LOC determination. LOC decisions also include input from the case manager, community-based case manager, medical professional, and other appropriate professionals.

For FFS members, the annual LOC reevaluation is conducted by the IME MSU. MCOs are responsible for annual LOC reevaluations of their members. The IME MSU reviews and approves all MCO reevaluations that indicate a change in the member's level of care. MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services.

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

Medical professionals (i.e., licensed physician, physician assistant or advanced registered nurse practitioner) perform the initial evaluation/complete the assessment tool. The IME requires that professionals completing the level of care determination are licensed RNs. Level of care decisions include input from the case manager, health home coordinator, community-based case manager, medical professional, and other appropriate professionals. There are occasions when the information obtained during the level of care review is in conflict, inconclusive or results in denial of level of care. For such occasions where the RN is unable to make a LOC determination based on the information available, or the information provided results in denial of LOC, the information is provided to the Medicaid Medical Director for a final determination. Only the Medicaid Medical Director can make LOC denial determinations.

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

IME Medical Services uses the following assessments to evaluate and reevaluate applicants and members:
Brain Injury Waiver
Ages 0 – 3 Case Management (CM) Comprehensive Assessment
Ages 4 -20 interRAI – Pediatric Home Care (PEDS-HC)and MPAI
Ages 21-64 interRAI – Home Care (HC)and MPAI

CM Comprehensive Assessment
This is the previous tool used for level of care determination prior to the implementation of the interRAI tools for the age groups listed above. The interRAI did not offer a tool for the age group from 0-3; therefore, the CM Comprehensive Assessment continues to be used for infants and children through age 3.

This assessment tool used is based on the *Minimum Data Set (MDS), the individual requires supervision, or limited assistance, provided on a daily basis by the physical assistance of at least one person, for dressing and personal hygiene activities of daily living as defined by the minimum data set section G, entitled Physical Functioning and Structural Problems

There is not a scoring system, but based on the MDS, the individual requires the establishment of a safe, secure environment due to modified independence (some difficulty in new situations only) or moderate impairment (decisions poor, cues and supervision required; never or rarely made a decision; danger to self or others) of cognitive skills for daily decision making. The following areas are assessed: (1) cognitive, mood and behavior patterns; (2) physical functioning-mobility; (3) skin condition; (4) pulmonary status; (5) continence; (6) dressing and personal hygiene; (7) nutrition; (8) nutrition; (9) medications; (10) communication; (11) psycho-social

interRAI – Home Care Assessments
The interRAI Home Care Assessment System (HC) has been designed to be a user-friendly, reliable, person-centered assessment system that informs and guides comprehensive care and service planning in community-based settings around the world. It focuses on the person's functioning and quality of life by assessing needs, strengths, and preferences, and facilitates referrals when appropriate. When used over time, it provides the basis for an outcome-based assessment of the person's response to care or services. The interRAI HC can be used to assess persons with chronic needs for care as well as those with post-acute care needs (for example, after hospitalization or in a hospital-at-home situation). Areas of review include: (1) cognitive; (2) mood and behavior patterns; (3) physical functioning – mobility; (4) skin condition; (5) pulmonary status; (6) continence; (7) dressing and personal hygiene – ADLS; (8) physical functioning – eating; (9) medications; (10) communication/hearing/vision patterns; and (11) prior living - psychosocial.

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

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

The interRAI HC Assessment Form is a Minimum Data Set screening tool that enables a trained assessor to assess multiple key domains of function, health, social support and service use. Particular interRAI HC items also identify persons who could benefit from further evaluation of specific problems of risks for functional decline. These are triggers that link the interRAI HC to a Clinical Assessment Protocol. The CAPS contain general guidelines for further assessment.

The HC system supports a variety of research-informed decision support tools that assist the assessor in planning and monitoring care. These include:
*Scales for ADLs, cognition, communication, pain, depression, and medical instability
*Clinical Assessment Protocols that contain strategies to address problem conditions as triggered by one or more HC item responses
*Screening systems to identify appropriate outreach and care pathways for prospective clients (the MI Choice and MAPLe systems)
*A quality monitoring system (Home Care Quality Indicators, or HCQIs)
*A case-mix system that creates distinct service-use intensity categories (RUG-III/HC)
IME Medical Services may request additional information from the service worker, case manager, health home coordinator, or community-based case manager to clarify or supplement the information submitted with the assessment. The results of the assessment are used to develop the plan of care. Because the same criteria are used for both institutional care and waiver services, the outcome is reliable, valid, and fully comparable.

The Case Management Comprehensive Assessment is utilized for children age 0-3 as the interRAI Pediatric Home Care Assessment is not rated for children age 3 and under. The Case Management Functional Assessment

The interRAI Pediatric Home Care Assessment (PEDS-HC) is a standardized assessment tool developed for use in programs serving children with special health care challenges. The PEDS-HC instrument is designed to be used to assess the home care challenges of children and youths ranging in age from 4 through 20 who are seeking or receiving long-term services or supports

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

It is the responsibility of the case manager or community-based case manager to assure the assessment is initiated as required to complete the initial level of care determination. For FFS members, the initial assessment is completed by the Department's Core Standardized Assessment(CSA) contractor and sent to the case manager or care coordinator who uploads the assessment to the IME MSU. For MCO members, the MCO is responsible to ensure the CSA is completed, and then uploaded the assessment to the IME MSU. The IME MSU is responsible for determining the level of care based on the completed assessment tool and supporting documentation from medical professionals. The Continued Stay Review (CSR) is completed annually and uses the same assessment tool as is used with the initial level of care determination. It is the responsibility of the case manager or community-based case manager to assure the assessment is initiated as required to complete the CSR. For fee-for-service participants, the ISIS system sends out a milestone 60 days prior to the CSR date to remind service workers, case manager, and health home coordinators of the upcoming annual LOC process.

MCOs are responsible for conducting the CSR level of care reevaluations for MCO members, using DHS designated tools, at least annually, and when the MCO becomes aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. Additionally, any member or provider can request a reevaluation at any time. Once the reevaluation is complete, the MCO submits the level of care or functional eligibility information via fax to the IME MSU. The State retains authority for determining Medicaid categorical, financial, level of care or needs-based eligibility and enrolling participants into a Medicaid eligibility category. MCOs track and report level of care and needs-based eligibility reevaluation data, including, but not limited to, reevaluation completion date. MCOs are required to notify DHS of any change in level of care and DHS retains final level of care determination authority. As the State is a neutral third party with final approval authority, there is no conflict of interest.

MCOs are contractually required to develop and maintain their own electronic community-based case management systems that include functionality to ensure compliance with the State's 1915(c) HCBS waiver and law. This includes, but is not limited to, the ability to capture and track: (i) key dates and timeframes such as enrollment date, date of development of the care plan, date of care plan authorization, date of initial service delivery, date of level of care and needs reassessments and dates of care plan updates and the functionality to notify the community-based case manager or care coordinator of care plan, assessment and reassessment deadlines; (ii) the care plan; (iii) all referrals; (iv) level of care assessment and reassessments; (v) needs assessments and reassessments; (vi) service delivery against authorized services and providers; (vii) actions taken by the community-based case manager or care coordinator to address service gaps; and (viii) case notes.

MCOs are required to employ the same professionals. Further, MCOs are contractually required to ensure on an ongoing basis that all staff has the appropriate credentials, education, experience and orientation to fulfill the requirements of their position. As applicable based on the scope of services provided under a subcontract, MCOs must ensure all subcontractor staff is trained as well. Staff training shall include, but is not limited to:
(i) contract requirements and State and Federal requirements specific to job functions;
(ii) training on the MCOs policies and procedures on advance directives;
(iii) initial and ongoing training on identifying and handling quality of care concerns;
(iv) cultural sensitivity training;
(v) training on fraud and abuse and the False Claims Act;
(vi) HIPAA training; (vii) clinical protocol training for all clinical staff;
(vii) clinical protocol training for all clinical staff;
(viii) ongoing training, at least quarterly, regarding interpretation and application of utilization management guidelines for all utilization management staff;
(ix) assessment processes, person-centered planning and population specific training relevant to the enrolled populations for all care managers; and
(x) training and education to understand abuse, neglect, exploitation and prevention including the detection, mandatory reporting, investigation and remediation procedures and requirements.

Policies and Procedures Manuals must also be provided to the MCO's entire staff and be incorporated into all training programs for staff responsible for providing services. Finally, MCOs must maintain documentation to confirm staff training, curriculum, schedules and attendance. DHS reserves the right to review training documentation and require the MCO to implement additional staff training.

MCOs are contractually required to develop and maintain their own electronic community-based case management systems that include functionality to ensure compliance with the State's 1915(c) HCBS waiver and law. This includes,

but is not limited to, the ability to capture and track:
(i) key dates and timeframes such as enrollment date, date of development of the care plan, date of care plan authorization, date of initial service delivery, date of level of care and needs reassessments and dates of care plan updates and the functionality to notify the community-based case manager or care coordinator of care plan, assessment and reassessment deadlines;
(ii) the care plan;
(iii) all referrals;
(iv) level of care assessment and reassessments;
(v) needs assessments and reassessments;
(vi) service delivery against authorized services and providers;
(vii) actions taken by the community-based case manager or care coordinator to address service gaps; and
(viii) case notes.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

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

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

  Specify the qualifications:

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

FFS
The IME CSA contractor is responsible for submitting timely level of care reevaluations of members. Reevaluations are considered timely if they are completed within twelve (12) months of the previous evaluation. Reevaluations of FFS members are tracked in the DHS Individualized Services Information System (ISIS). An ISIS milestone is sent out to the FFS CSA contractor 60 days before the reevaluation is due.

On a weekly basis, an ISIS CSR report is extracted to identify FFS overdue reevaluations. The list is sent to the management team for DHS Targeted Case Management for resolution. The DHS TCM submits a weekly status report to the designated HCBS program manager for monitoring with conferencing as needed.

A CSR or re-evaluation report is also available through ISIS to track overdue reevaluations and is monitored by Medical Services, the Bureau of Long Term Care (BLTC), and IME.

MCO
Reevaluations of MCO members are also tracked in the DHS Individualized Services Information System (ISIS) for IME oversight. However, MCOs are also responsible for recording timely completion of level of care reevaluations of members. One hundred percent (100%) of member level of care reevaluations must be completed within twelve (12) months of the previous evaluation. ISIS is queried weekly to monitor the status of MCO LOC determinations. This information is shared with MCO account managers. DHS reserves the right to audit MCO application of level of care criteria to ensure accuracy and appropriateness.

MCOs are contractually required to develop and maintain their own electronic community-based case management systems that include functionality to ensure compliance with the State's 1915(c) HCBS waiver and law. This includes, but is not limited to, the ability to capture and track: (i) key dates and timeframes such as enrollment date, date of development of the care plan, date of care plan authorization, date of initial service delivery, date of level of care and needs reassessments and dates of care plan updates and the functionality to notify the community-based case manager or care coordinator of care plan, assessment and reassessment deadlines; (ii) the care plan; (iii) all referrals; (iv) level of care assessment and reassessments; (v) needs assessments and reassessments; (vi) service delivery against authorized services and providers; (vii) actions taken by the community-based case manager or care coordinator to address service gaps; and (viii) case notes.

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

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
LC-a1: IME will measure the number and percent of approved LOC decisions.
Numerator: # of completed LOC; Denominator: # of referrals for LOC.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FFS and MCO members will be pulled from ISIS for this measure. IME MSU completes all initial level of care determinations for both FFS and MCO populations.

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

☒ **Other** Specify: contracted entity	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

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

Performance Measures

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

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

Performance Measure:
LC-c1: The IME shall determine the number and percent of initial level of care decisions that were accurately determined by applying the approved LOC criterion using standard operating procedures. Numerator: # of LOC decisions that were accurately determined by applying the correct criteria as defined in the waiver; Denominator: # of reviewed LOC determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
IME MQUIDS and OnBase

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5% with 95% confidence level
☒ **Other**	☐ **Annually**	☐ **Stratified**

Specify: Contracted Entity		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Data for completed LOC is collected quarterly through reports generated through ISIS, MQUIDS, and OnBase. This data is monitored for trends from an individual and systems perspective.
Monthly a random sample of LOC decisions is selected from each reviewer. IQC activity is completed on the random sample. This level of scrutiny aids in early detection of variance from the stated LOC criteria.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The state's Medical Services Unit performs internal quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred, the unit undertakes additional training for staff.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

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

During enrollment of fee-for-service members, ISIS requires that case managers (CM) and health home coordinators attest to having offered a choice between HCBS or institutional services. Choice is verified by : (1) marking the waiver box on the application; (2) sending a written request asking for waiver services; or (3) verbally confirming the member's choice with the income maintenance worker and the case manager or health home coordinator documents the conversation.

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

MCO
MCO community based case managers are required ensure that members are offered choice according to their respective MCO processes and forms, which are reviewed and approved by DHS.The MCOs provide oversight of service planning by reviewing the person centered service plan to determine if choice between waiver and institutional care has been provided and provider choice is offered. During the IPES member telephone surveys, the MCO asks members if they are offered choice of providers.

In addition, the IME Medical Services Unit (MSU) reviews the person centered service plan to determine if provider choice (including CCO) is offered.

The HCBS Unit, during the IPES member telephone surveys, asks members if they are offered choice of providers.

The IME's contractor for HCBS Oversight conducts monthly ride-along activities for MCO service plan coordination and evaluates compliance with service planning requirements, including choice between institutional and HCBS services. Feedback is provided to the MCO account managers, who then follow up on any necessary corrective actions.

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

FFS
Freedom of Choice forms for fee-for-service members is documented in member service plans and in ISIS.

MCO
MCOs are responsible for maintaining records that fully disclose the extent of services provided to members for a minimum of seven years, and must furnish such information to duly authorized and identified agents or representatives of the state and federal governments. The MCOs maintain copies of freedom of choice forms in the MCO database and the member's electronic health record.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Iowa DHS adopts the policy as set forth in Title VI of the Civil Rights Act prohibiting national origin discrimination as it affects people with limited English proficiency. DHS shall provide for communication with people with limited English proficiency, including current and prospective patients or clients, family members and participants to ensure them an equal opportunity to benefit from services. DHS has developed policies and procedures to ensure meaningful access for people with limited English proficiency. This includes procedures to:

- Identify the points of contact where language assistance is needed.
- Identify translation and interpretation resources, including their location and their availability.
- Arrange to have these resources available in timely manner.
- Determine the written materials and vital documents to be translated, based on the populations with limited English proficiency and ensure their transition.
- Determine effective means for notifying people with limited English proficiency of available translation services available at no cost.
- Train department staff on limited English proficiency requirements and ensure their ability to carry them out.
- Monitor the application of these policies on at least an annual basis to ensure ongoing meaningful access to services.

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

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

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

- MCOs must provide language services at no cost to limited English proficiency members, and all written materials shall be provided in English and Spanish, as well as any additional prevalent languages identified by the State or through an analysis of member enrollment (i.e., any language spoken by at least five percent (5%) of the general population in the MCO's service area).

- MCOs must provide oral interpretation services free of charge to each member (this applies to all non-English languages, and is not limited to prevalent languages), and MCOs must notify all members that oral interpretation and translated written information is available and how to access those services. Written materials must include taglines in prevalent languages regarding how to access materials in alternative languages.
- MCOs must ensure that service plans reflect cultural considerations of the member and that service plan development is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b).
- MCOs must operate member services helplines that are available to all callers, and an automated telephone menu options must be made available in English and Spanish.
- MCOs must maintain member websites and mobile applications available in English and Spanish that are accessible and functional via cell phone.

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

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04060 adult day services (social model)

Category 2: 04 Day Services

Sub-Category 2: 04050 adult day health

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on regular or intermittent basis in a day care center. 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.

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:

Adult day services has an upper rate limit if there is no Veterans Administration contract. The upper rate limits are pulsihed in 441 IAC Chpater 79. The rates are subject to change on a yearly basis. A unit of service is 15 minutes, a half day (1 to 4 hours), a full day (4.25 to 8 hours) or an extended day (8.25 to 12 hours). Transportation is not a required element of adult day services but if the cost of transportation is provided and charged to Medicaid, the cost of transportation must be included in the adult day health rate. The case manager is responsible for authorizing services based on member need and monitors the service to assure that needed services are provided. If transportation to and from the ADC is needed (based on the ADC providers transportation), the CM will authorize and monitor the authorized transportation as needed.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Agencies

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 as required by the DIA, the ADC licensing entity.
(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:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker

Category 2:	Sub-Category 2:

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

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. Components of the service are directly related to the care of the member and include:
a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and dishes.
c. Meal preparation planning and preparing balanced meals.

The member's plan of care will address how the member's health care needs are being met. Overlapping of services is avoided by the use of a service worker/case manager who manages all services and the enter into the ISIS system. The service worker/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. The service worker/case worker will monitor the plan.

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

A unit of service is 15 minutes.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Home Care Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

espite 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.

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 $7,334.62 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. The current IME policy identifies that respite is not appropriate for a paid caregiver. If respite is needed, another CDAC provider can be employed. 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	Group living foster care facilities for children
Agency	Child care facilities
Agency	Home care agencies
Agency	Assisted living programs
Agency	Respite care providers certified under the Intellectual Disability or Brain Injury Waivers.
Agency	Home health agencies
Agency	Adult day care providers
Agency	Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals
Agency	Camps

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Group living foster care facilities for children

Provider Qualifications

License *(specify):*

Group living foster care facilities for children licensed by the department according to 441 Chapters 112 and 114 to 116 and child care centers licensed according to 441 Chapter 109.

Certificate *(specify):*

Other Standard *(specify):*

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.

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:

Child care facilities

Provider Qualifications

License *(specify):*

Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441 Chapter 110.

Certificate *(specify):*

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home care agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Assisted living programs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Assisted Living programs certified by the Department of Inspections and Appeals as defined in IAC 481 Chapter 69.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified to provide respite by the Department's Home and Community Based Services Quality Oversight Unit as outlined in Iowa Administrative Code 441-77.37

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home health agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult day care providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Adult day care providers 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:
"Accredited" means that the program has received accreditation from an accreditation entity recognized in Department of Inspections (DIA) rules for Adult Day Service: CARF or a recognized accrediting entity designated by the Department of Inspections and Appeals (DIA).
"Nonaccredited" means that the program has been certified under the provisions by DIA but has not received accreditation from the accreditation entity recognized by DIA
NonAccredited program Application content:
70.4(1) A list that includes the names, addresses, and percentage of stock, shares, partnership or other equity interest of all officers, members of the board of directors and trustees, as well as stockholders, partners or any individuals who have greater than a 10 percent equity interest in each of the following, as applicable: a. The real estate owner or lessor; b. The lessee; and c. The management company responsible for the day-to-day operation of the program.
70.4(2) A statement disclosing whether the individuals listed in subrule 70.4(1) have been convicted of a felony or an aggravated or serious misdemeanor or found to be in violation of the child abuse or dependent adult abuse laws of any state.
70.4(3) A statement disclosing whether any of the individuals listed in subrule 70.4(1) have or have had an ownership interest in an adult day services program, assisted living program, elder group home, home health agency, licensed health care facility as defined in Iowa Code section 135C.1, or licensed hospital as defined in Iowa Code section 135B.1, which has been closed in any state due to removal of program, agency, or facility licensure or certification or due to involuntary termination from participation in either the Medicaid or Medicare program; or have been found to have failed to provide adequate protection or services to prevent abuse or neglect of residents, patients, tenants or participants.
70.4(4) The policy and procedure for evaluation of each participant. A copy of the evaluation tool or tools to be used to identify the functional, cognitive and health status of each participant shall be included.
70.4(5) The policy and procedure for service plans.
70.4(6) The policy and procedure for addressing medication needs of participants.
70.4(7) The policy and procedure for accidents and emergency response.
70.4(8) The policies and procedures for food service, including those relating to staffing, nutrition, menu planning, therapeutic diets, and food preparation, service and storage.
70.4(9) The policy and procedure for activities.
70.4(10) The policy and procedure for transportation.
70.4(11) The policy and procedure for staffing and training.
70.4(12) The policy and procedure for emergencies, including natural disasters. The policy and procedure shall include an evacuation plan and procedures for notifying legal representatives in emergency situations as applicable.
70.4(13) The policy and procedure for managing risk and upholding participant autonomy when participant decision making results in poor outcomes for the participant or others.
70.4(14) The policy and procedure for reporting incidents including dependent adult abuse as required in rule 481—67.2(231B,231C,231D).
70.4(15) The policy and procedure related to life safety requirements for a dementia-specific program as required by subrule 70.32(2).
70.4(16) The participant contractual agreement and all attachments.
70.4(17) If the program contracts for personal care or health-related care services from a certified home health agency, a mental health center or a licensed health care facility, a copy of that entity's current license or certification.
70.4(18) A copy of the state license for the entity that provides food service, whether the entity is the program or an outside entity or a combination of both.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing facilities, intermediate care facilities for the mentally retarded, or 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. Facilities must be licensed as a nursing facility or intermediate care facilities for the intellectually disabled, or a hospital by the Iowa Department of Inspections and Appeals (DIA)

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.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Home Health Aide

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08020 home health aide
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

HHome 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, including EPSDT, must be accessed before seeking payment through the waiver. This waiver service is only provided to individuals age 21 and over. All medically necessary Home Health Aide services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. 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:
(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. All medically necessary Home Health Aide services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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 consumers individual comprehensive plan.
b. A unit is one hour.
c. A maximum of 14 units are available per week. If additional home health aide service is needed, a request for an exception to policy may be submitted to the Department for review.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Home Health Aide

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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:
05 Nursing	05020 skilled nursing

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

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

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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. This service is only provided to members age 21 and over. All medically necessary nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Where there is a potential for overlap, services must first be exhausted under IDEA or the Rehabilitation Act of 1973.

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

A unit of service is an hour. 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.

This waiver service is only provided to individuals age 21 and over. All medically necessary Nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Nursing

Provider Category:
Agency
Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Provider qualifications specified in the State Plan apply.

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:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The Financial Management Service (FMS) is necessary for all members choosing the self-direction option, and 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 as contained in the Iowa Administrative Code 441-79.1; the IAC will be revised to reflect any changes in the upper payment limit. The upper limit may change periodically with legislatively 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:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

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

This service is necessary for members who choose the self-direction option at a maximum of 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 four months and quarterly after that. If a member needs additional support brokerage service, the member will need prior authorization from the state.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Support Broker

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Independent Support Broker

Provider Category:

Individual

Provider Type:

Individual Support Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management System Provider, Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Once initially trained, the Individual Support Broker is placed on a Independent Support Brokerage registry that is maintained at the Iowa Department of Human Services Iowa Medicaid Enterprise.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer Directed Attendant Care - Skilled

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Consumer Directed Attendant Care 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 15 minutes provided by an individual or an agency.
Each service shall be billed in whole units.
CDAC may be provided to a recipient of in-home health related care services, but not at the same time. There is an upper limit for both aency and individual providers. These are subject to change on a yearly basis.
d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.
e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

These services may not duplicate services provided under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

The services under the AIDS/HIV waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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 service providers
Agency	Home Care Provider
Agency	Community Action Agency
Agency	Chore providers
Agency	Assisted living programs
Agency	Home Health Agency
Agency	Supported Community Living Providers
Individual	Any individual who contracts with the member

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Adult day service providers

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 - Skilled

Provider Category:
Agency
Provider Type:

Home Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

Other Standard *(specify):*

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

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

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

For skilled CDAC, the service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Community Action Agencies as designated in Iowa Code 216A.93.

Other Standard *(specify):*

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

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

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

For skilled CDAC, the service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Chore providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

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

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

For skilled CDAC, the service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Assisted living programs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Assisted living programs that are certified by the Iowa department of inspections and appeals under 481—Chapter 69.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Supported Community Living Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Any individual who contracts with the member

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer-Directed Attendant Care - Unskilled

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08050 homemaker
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Consumer-directed attendant care (CDAC) 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 and is monitored by the case manager as part of inclusion in the member's plan. CDAC is not duplicative of self-directed personal care services. CDAC–unskilled is one of eight ID waiver services that may be used to create a self-directed budget amount CCO. When CDAC is authorized in the CCO budget, the case manager is responsible to assure that the service needs are being met and there is no duplication of services.

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 provided by an individual or an agency.
Each service shall be billed in whole units.
CDAC may be provided to a recipient of in-home health related care services, but not at the same time. There is an upper limit for both aency and individual providers. These are subject to change on a yearly basis.
d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.
e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

These services may not duplicate services provided under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

The services under the AIDS/HIV waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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	Assisted living programs
Agency	Home Care Provider
Individual	Any individual who contracts with the member
Agency	Community Action Agency
Agency	Supported Community Living
Agency	Chore providers
Agency	Adult Day Service Providers

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Assisted living programs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Any individual who contracts with the member

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Community action agencies as designated in Iowa Code section 216A.92 and 93.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Supported Community Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

Chore providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chore providers subcontracting with area agencies on aging with letters from the area agencies on aging stating that the organization is qualified to provide chore services.
IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Adult Day Service Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or if the number of persons who comprise the groups exceeds six, the actual number of persons who comprise the group.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **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	Licenses Hospice Agencies
Agency	Mental Health Service Providers
Agency	Community Mental Health Centers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling

Provider Category:
Agency
Provider Type:

Licenses Hospice Agencies

Provider Qualifications

License *(specify):*

Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling

Provider Category:

Agency

Provider Type:

Mental Health Service Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling

Provider Category:

Agency

Provider Type:

Community Mental Health Centers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home delivered meals are meals prepared elsewhere and delivered to a waiver member's residence. Each meal shall ensure the member receives a minimum of one third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National of the National Research Council of the National Academy of Sciences. The meal may be a liquid supplement which meets the minimum one third standard.

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

A maximum of 14 meals is allowed per week. A unit of service is a meal. The members plan of care will address how the member's health care needs are being met. Services must be authorized in the service plan. The service worker will monitor the plan.

Services will be monitored by the service worker through the service plan to avoid duplication with other services such as with homemaker and consumer-directed attendant care. While homemaker and CDAC may cover meal prep and clean up; home delivered meals covers the cost of food which is not covered under any other waiver service.

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

- ☒ **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	Restaurants
Individual	Assisted Living Facility
Agency	Hospitals
Agency	Nursing Facility
Agency	Home Care Agency
Agency	Medical Equipment and Supply Dealers
Agency	Area Agencies on Aging
Agency	Subcontractor with Area Agencies on Aging
Agency	Community Action Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Home care providers meeting the standards set forth in subrule 77.33(4):
a. Certified as a home health agency under Medicare, or
b. Authorized to provide similar services through a contract with the Iowa department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Restaurants

Provider Qualifications

License *(specify):*

Licensed and inspected under Iowa Code Chapter 137F:
137F.3 Authority to enforce.
1. The director shall regulate, license, and inspect food establishments and food processing plants and enforce this chapter pursuant to rules adopted by the department in accordance with chapter 17A. Municipal corporations shall not regulate, license, inspect, or collect license fees from food establishments and food processing plants, except as provided in this section.

137F.4 License required.
A person shall not operate a food establishment or food processing plant to provide goods or services to the general public, or open a food establishment to the general public, until the appropriate license has been obtained from the regulatory authority. Sale of products at wholesale to outlets not owned by a commissary owner requires a food processing plant license. A license shall expire one year from the date of issue. A license is renewable. All licenses issued under this chapter that are not renewed by the licensee on or before the expiration date shall be subject to a penalty of ten percent per month of the license fee if the license is renewed at a later date.

137F.10 Regular inspections.
The appropriate regulatory authority shall provide for the inspection of each food establishment and food processing plant in this state in accordance with this chapter and with rules adopted pursuant to this chapter in accordance with chapter 17A. A regulatory authority may enter a food establishment or food processing plant at any reasonable hour to conduct an inspection. The manager or person in charge of the food establishment or food processing plant shall afford free access to every part of the premises and render all aid and assistance necessary to enable the regulatory authority to make a thorough and complete inspection. As part of the inspection process, the regulatory authority shall provide an explanation of the violation or violations cited and provide guidance as to actions for correction and elimination of the violation or violations.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Individual
Provider Type:

Assisted Living Facility

Provider Qualifications
License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education than what would be contained in IAC 481-chapter 69. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Verification of Provider Qualifications
Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:

Hospitals

Provider Qualifications
License *(specify):*

Enrolled as a Medicaid Provider as described in IAC 441 Chapter 77.3: All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

Certificate *(specify):*

Other Standard *(specify):*

Enrolled 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: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Nursing Facility

Provider Qualifications

License *(specify):*

Licensed pursuant to Iowa Code Chapter 135C and qualifying for Medicaid enrollment as described in IAC 441 Chapter 81.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:

Home Care Agency

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Home care providers meeting the standards set forth in subrule 77.33(4):
a. Certified as a home health agency under Medicare, or
b. Authorized to provide similar services through a contract with the Iowa department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:

Medical Equipment and Supply Dealers

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Medical equipment and supply dealer certified to participate in the Medicaid program as defined by IAC 441 Chapter 77.10. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Area Agencies on Aging

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Area agencies on aging as designated according to department on aging rules IAC 17—4.4(231)

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements. The department may, in its discretion, designate one area agency on aging to serve more than one planning and service area.
4.4(2)Designation requirements for units of general purpose local government. Whenever the department designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984 or designates an existing area agency on aging, the department shall give the right of first refusal to a unit of general purpose local government if:
a. The unit of general purpose local government can meet the requirements established to serve as an area agency on aging
pursuant to state and federal law; and
b. The unit of general purpose local government's geographical boundaries and the geographical boundaries of the planning
and service area are reasonably contiguous.
4.4(3)Qualifications to serve. Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following:
a. An established office of aging operating within a planning and service area;
b. Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose
of serving as an area agency on aging by the chief elected official of such unit;
c. Any office or agency designated by the appropriate chief elected officials of any combination of units of general
purpose local government to act only on behalf of such combination for such purpose;
d. Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such
agency, which for designation purposes is under the supervision or direction of the department and which can and will
engage only in the planning or provision of a broad range of supportive services or nutrition services within such
planning and service area; or
e. Any other entity authorized by the Older Americans Act.

4.4(8)Official designation. An entity shall be designated the area agency on aging upon the commission's acceptance of the department's proposed recommendation for designation, the commission's approval of the area agency on aging area plan, and execution of the associated contract between the department and the area agency on aging. Official designation of an area agency on aging shall not occur until final disposition of all appeals.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Subcontractor with Area Agencies on Aging

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the Area Agencies on Aging stating the organization is qualified to provide home-delivered meals services.

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements. The department may, in its discretion, designate one area agency on aging to serve more than one planning and service area.
4.4(2)Designation requirements for units of general purpose local government. Whenever the department designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984 or designates an existing area agency on aging, the department shall give the right of first refusal to a unit of general purpose local government if:
a. The unit of general purpose local government can meet the requirements established to serve as an area agency on aging
pursuant to state and federal law; and
b. The unit of general purpose local government's geographical boundaries and the geographical boundaries of the planning
and service area are reasonably contiguous.
4.4(3)Qualifications to serve. Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following:
a. An established office of aging operating within a planning and service area;
b. Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose
of serving as an area agency on aging by the chief elected official of such unit;
c. Any office or agency designated by the appropriate chief elected officials of any combination of units of general
purpose local government to act only on behalf of such combination for such purpose;
d. Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such
agency, which for designation purposes is under the supervision or direction of the department and which can and will
engage only in the planning or provision of a broad range of supportive services or nutrition services within such
planning and service area; or
e. Any other entity authorized by the Older Americans Act.

4.4(8)Official designation. An entity shall be designated the area agency on aging upon the commission's acceptance of the department's proposed recommendation for designation, the commission's approval of the area agency on aging area plan, and execution of the associated contract between the department and the area agency on aging. Official designation of an area agency on aging shall not occur until final disposition of all appeals.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Community action agencies as designated in Iowa Code section 216A.93

Other Standard *(specify):*

216A.92 Division of community action agencies.
1. The division of community action agencies is established. The purpose of the division of community action agencies is to strengthen, supplement, and coordinate efforts to develop the full potential of each citizen by recognizing certain community action agencies and supporting certain community-based programs delivered by community action agencies.
2. The division shall do all of the following:
a. Provide financial assistance for community action agencies to implement community action programs, as permitted by the community service block grant and subject to the funding made available for the program.
b. Administer the community services block grant, the low-income energy assistance block grants, department of energy funds for weatherization, and other possible funding sources. If a political subdivision is the community action agency, the financial assistance shall be allocated to the political subdivision.
c. Implement accountability measures for its programs and require regular reporting on the measures by the community action agencies.
d. Issue an annual report to the governor and general assembly by July 1 of each year.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

Members (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 service worker/case manager and Independent Support Broker (ISB) to budget services. If a member is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.

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

Individual directed goods and services must be documented on the individual budget. The individual budget limit will be based on the service plan and the need for the services available to be converted. A utilization adjustment rate will be applied to the individual budget amount.

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

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

- ☒ **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	Individual Directed Goods and Services
Individual	Individual Directed Goods and Services

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Individual Directed Goods and Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Members who elect the consumer choices option may choose to purchase individual directed goods and services. Providers must have current liability and workers' compensation coverage as required by law.

All personnel providing self-directed community supports and employment shall:
(1) Be at least 18 years of age.
(2) Be able to communicate successfully with the member.
(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
(5) Not be the parent or stepparent of a minor child member or the spouse of a member.
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, Financial Management System (FMS) Provider and Iowa Department of Human Services are responsible for the verification of provider qualifications. The member verifies that employees hired have the skills and training needed to provide direct services. The FMS is responsible for the employer tasks such as completing employee background checks, verify employee citizenship or aliens status, and assuring wages are within the Department of Labor standards. The Department verifies the employee criminal and abuse background checks.

Frequency of Verification:

Verification of qualifications occurs at the time of initial use by a member in the CCO program

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:

Individual Directed Goods and Services

Provider Qualifications

License *(specify):*

An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation. The type of license needed will be dependent on the type of good or service being purchased through CCO. It is the responsibility of the member to assure that any good or service being purchased through CCO that requires licensure has the needed licensure prior to the purchase of the good or service.

Certificate *(specify):*

Other Standard *(specify):*

Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.
a. A business providing individual-directed goods and services shall:
(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
(2) Have current liability and workers' compensation coverage.
b. An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.
c. 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 timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, Financial Management System (FMS) Provider and Iowa Department of Human Services are responsible for the verification of provider qualifications. The member verifies that employees hired have the skills and training needed to provide direct services. The FMS is responsible for the employer tasks such as completing employee background checks, verify employee citizenship or aliens status, and assuring wages are within the Department of Labor standards. The Department verifies the employee criminal and abuse background checks.

Frequency of Verification:

Verification of qualifications occurs at the time of initial use by a member in the CCO program

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Self Directed Community Support and Employment

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's 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.

Once authorized in the monthly CCO budget, the member must use the budget to get their assessed needs met. It is the responsibility of the member's case manager or community based case manager to monitor the member's CCO use to assure that the member is using the budget to get their service needs met.

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

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Individual

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. Providers must have current liability and workers' compensation coverage as required by law.

All personnel providing self-directed community supports and employment shall:
(1) Be at least 18 years of age.
(2) Be able to communicate successfully with the member.
(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
(5) Not be the parent or stepparent of a minor child member or the spouse of a member.
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, Financial Management System (FMS) Provider and Iowa Department of Human Services are responsible for the verification of provider qualifications. The member verifies that employees hired have the skills and training needed to provide direct services. The FMS is responsible for the employer tasks such as completing employee background checks, verify employee citizenship or aliens status, and assuring wages are within the Department of Labor standards. The Department verifies the employee criminal and abuse background checks.

Frequency of Verification:

Verification of qualifications occurs at the time of initial use by a member in the CCO program

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Agency

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. Providers must have current liability and workers' compensation coverage as required by law.

All personnel providing self-directed community supports and employment shall:
(1) Be at least 18 years of age.
(2) Be able to communicate successfully with the member.
(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
(5) Not be the parent or stepparent of a minor child member or the spouse of a member.
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, Financial Management System (FMS) Provider and Iowa Department of Human Services are responsible for the verification of provider qualifications. The member verifies that employees hired have the skills and training needed to provide direct services. The FMS is responsible for the employer tasks such as completing employee background checks, verify employee citizenship or aliens status, and assuring wages are within the Department of Labor standards. The Department verifies the employee criminal and abuse background checks.

Frequency of Verification:

Verification of qualifications occurs at the time of initial use by a member in the CCO program

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Self Directed Personal Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction

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

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

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Self-directed 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.

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.

The services under the AIDS/HIV Waiver are limited to the additional services not otherwise covered under the state plan, including EPSDT, but consistent with the waiver objectives of avoiding institutionalization.

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**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Self Directed Personal Care

Provider Category:

Agency

Provider Type:

Business

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Members who elect the consumer choices option may choose to purchase self directed personal care. Providers must have current liability and workers' compensation coverage as required by law.

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

The services under the Intellectual Disabilities Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, Financial Management System (FMS) Provider and Iowa Department of Human Services are responsible for the verification of provider qualifications. The member verifies that employees hired have the skills and training needed to provide direct services. The FMS is responsible for the employer tasks such as completing employee background checks, verify employee citizenship or aliens status, and assuring wages are within the Department of Labor standards. The Department verifies the employee criminal and abuse background checks.

Frequency of Verification:

Verification of qualifications occurs at the time of initial use by a member in the CCO program

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Self Directed Personal Care

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation. The type of license needed will be dependent on the type of good or service being purchased through CCO. It is the responsibility of the member to assure that any good or service being purchased through CCO that requires licensure has the needed licensure prior to the purchase of the good or service.

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

Response: The following was added to the other standards section: The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:
(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.

Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Every four years

Appendix C: Participant Services

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

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

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

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

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

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

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

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

☐ **As a primary care case management system service under a concurrent managed care authority.** *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:

FFS
Case managers or integrated health home coordinators provide case management services for members enrolled in the State's §1915(c) AIDS/HIV waiver. Services are reimbursed through an administrative function of DHS.

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.

MCO
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.

MCO community-based case managers or integrated health home care coordinators 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 or integrated health home care coordinator contacts members at least monthly, either in person or by phone, with an interval of at least fourteen calendar days between contacts.

All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned. MCOs are contractually required to ensure the delivery of services in a conflict free manner consistent with Balancing Incentive Program requirements. DHS approves and monitors all MCO policies and procedures to ensure compliance.

Appendix C: Participant Services

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

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

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

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

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

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

1. For purposes of this section and section 249A.30 unless the context otherwise requires:
a. “Member” 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 member (individual approved by the department to receive services under a waiver) or with access to a member when the member 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. During each of these review processes, the HCBS Quality Oversight unit reviews the provider’s quality data collected by the provider to measure compliance with the criminal background checks. The HCBS Quality oversight unit also reviews a random sample of personnel files to verify the background checks are present in the file and reflects the provider’s quality review.

The State HCBS Quality Oversight Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. There are four types of provider site visits where agency personnel records are reviewed; periodic, certification, focused and targeted. At a minimum all providers have a periodic review conducted every five years. Providers of respite services require a certification review that is conducted every one to three years, depending on the results of the review. Focused reviews occurs annually for a select group of providers randomly selected to review a quality topic selected by the Department. Targeted reviews are conducted as needed based on complaints received by the Department or specific provider quality concerns identified.

Criminal history and abuse registry 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 members; and
2. An employee who provides direct services to members 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.“Member” 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 member (individual approved by the department to receive services under a waiver) or with access to a member when the member 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 (CCO) under this waiver are required to complete child and dependent adult abuse background checks prior to employment with a member. The Fiscal Management Services (FMS) 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 member may provide services to an adult waiver member. This applies to guardians of their adult children or of other adults, age 18 or older, for whom they have been legally appointed as the guardian. Parents and guardians of members age 17 and younger may not be paid providers of service. The person who is legally responsible for an adult member may be a Consumer Directed Attendant Care (CDAC) provider or an employee under the Consumer Choices Option (CCO) program. 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 member and to avoid institutionalization would not be considered extraordinary. If the legal representative is an employee through CDAC or CCO, the legal representative must have the skills needed to provide the services to the member. In many situations, the member requests the legal representative to provide services, as the legal representative knows the member and their needs best. In other circumstances, there are no other qualified providers available when the service is needed or a lack of staff in the area to provide the service.

Through the person-centered planning process, the comprehensive service plan is developed. If the member has a legal representative who is also their service provider, the care plan will address how the DHS case manager or MCO community based case manager will oversee the service provision to ensure care is delivered in the best interest of the member.

The rate of pay and the care provided by the legally responsible person is identified and authorized in the member’s plan of care that is authorized and monitored by a DHS case manager or MCO community based case manager. Service plans are monitored to assure that authorized services are received. For fee-for-service members, 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 members 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.

The parent of a minor child, the spouse or a legal representative of a member may not be a paid provider of service to the member. Per to 441 Iowa Administrative Code 441-79.9(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.”

☒ **Self-directed**

☐ **Agency-operated**

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 member's relative or legal guardian may provide services to a member. Payments may be made to any relative who is not the parent of a minor child, a spouse, or a legal representative of the member. 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. 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. The relative or legal guardian through the CCO program may provide the following self-directed goods and services:
1. Consumer-directed attendant care (unskilled).
2. Basic individual respite care.
3. Self Directed Goods and Services

When the relative or legal guardian is the CDAC or CCO provider, the case manager 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 member's service plan that is authorized and monitored by the member's case manager, health home coordinator, or community-based case manager.

Case managers and community-based case managers are responsible to monitor service plans and assure the services authorized in the member'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 or 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.

○ **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 members. 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 managers, health home coordinators, market to qualified providers to enroll in Medicaid.

MCOs are responsible for oversight of their provider networks.
The State ensures that LTSS providers are given the opportunity for continued participation in the managed care networks by regularly monitoring the managed care organization provider network and evaluating rationales for not having providers in their networks. While the number of providers not contracted with all three managed care organizations is small, the rationale includes providers not accepting the "floor" rates determined by the State and wanting enhanced rates. The State additionally tracks on provider inquiries and complaints which includes complaints related to network access and credentialing.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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-a1 The IME will measure the number of newly enrolled licensed or certified waiver provider enrollment applications verified against the appropriate licensing or certification entity Numerator = # of newly enrolled waiver providers verified against appropriate licensing or certification entity prior to providing services Denominator = # of newly enrolled licensed or certified waiver providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Encounter data, claims data and enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.

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

Data Aggregation and Analysis:

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

Performance Measure:
QP-a2: The IME will measure the number of licensed or certification waiver provider re-enrollments verified against the appropriate licensing and/or certification entity. Numerator = number of waiver providers verified against appropriate licensing and/or certification entity during re-enrollment. Denominator = the number of licensed or certified waiver re-enrolled providers.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:
Re-enrollment information out of ISIS. All MCO HCBS providers must be re-enrolled as verified by the IME Provider Services Unit every five 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: Contract entity	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

For each performance measure the State will use to assess compliance with the statutory assurance,

complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
QP-b1: The IME shall determine the number and percent of CDAC providers that met waiver requirements prior to direct service delivery. Numerator = # of CDAC providers who met waiver requirements prior to service delivery; Denominator = # of CDAC enrolled providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.

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

Data Aggregation and Analysis:

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

Performance Measure:
QP-b2: The IME shall determine the number of Consumer Choice Option (CCO) providers that met waiver requirements prior to direct service delivery. Numerator = number of CCO providers who met waiver requirements prior to service delivery; Denominator = number of CCO enrolled providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Financial Management Services (FMS) provider data collection

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: FMS Provider	☐ **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-b3: The IME shall determine the number and percent of non-licensed/noncertified providers that met waiver requirements prior to direct service delivery. Numerator = # of non-licensed/noncertified providers who met waiver requirements prior to service delivery; Denominator = # of non-licensed/noncertified enrolled providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Enrollment Records, Individualized Services Information System (ISIS), Claims

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
QP-c1: The IME will measure the total number and percent of providers, specific by waiver, that meet training requirements as outlined in State regulations. Numerator = # of reviewed HCBS providers which did not have a corrective action plan issued related to training; Denominator = # of HCBS waiver providers that had a certification or periodic quality assurance review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider's evidence of staff training and provider training policies. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed

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

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

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The IME Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment.
All MCO providers must be enrolled as verified by IME Provider Services.

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 if noncompliance persists.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

If it is discovered by Provider Services Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, the provider is required to correct deficiency prior to enrollment or reenrollment approval. Until the provider make these corrections, they are ineligible to provide services to waiver members. All MCO providers must be enrolled as verified by IME Provider Services, so if the provider is no longer enrolled by the IME then that provider is no longer eligible to enroll with an MCO.

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 required changes in individual provider policy.

PMs QP-a1, QP-a2, QP-b1, QP-b2, QP-b3 discovery process includes reviewing the provider's qualifications prior to enrollment and upon reenrollment. Provider qualifications include ensuring that the provider is performing child and dependent adult abuse checks and criminal record checks in accordance with Code of Iowa 135C.33 https://www.legis.iowa.gov/docs/code/2019/135C.33.pdf, 441 Iowa Administrative Code 79.14 https://www.legis.iowa.gov/docs/iac/chapter/441.79.pdf and 441 IAC 119 https://www.legis.iowa.gov/docs/iac/chapter/09-25-2019.441.119.pdf

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**

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is

authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

If it is discovered by Provider Services Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, they are required to correct deficiency prior to enrollment or reenrollment approval. Until they make these corrections, they are ineligible to provide services to waiver members.

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the

development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Service planning responsibilities for FFS members in the AIDS/HIV Waiver is completed by DHS Targeted Cases Management. DHS TCM is an arm of the DHS Mental Health and Disability Services. DHS TCM is CARF certified for case management. DHS targeted case managers (TCM) must be licensed social workers.

TCM qualifications include: graduation from an accredited four-year college or university; or the equivalent of four years of full-time technical work experience involving direct contact with people in overcoming their social, economic, psychological, or health problems; or an equivalent combination of education and experience substituting the equivalent of one year of full-time qualifying work experience for one year (thirty semester or equivalent hours) of the required education to a maximum substitution of four years.

In addition, DHS TCMs may be required to have the following specified experience in the following areas if they are specifically working with these populations:

- Developmental disabilities: a minimum of one-year full-time (or equivalent part-time) experience in delivering or coordinating services for persons with developmental disabilities (i.e., severe, chronic mental or physical impairments). Positions that meet the intellectual disability background noted above will normally meet this selective area too. Experience in providing services and treatment to autistic children or persons with epilepsy or cerebral palsy will also qualify.
- Intellectual disability: a minimum of one year of full-time (or equivalent part-time) experience in delivering or coordinating services for persons with significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior manifested during the developmental period.

MCO
MCO community-based case managers develop service plans for members receiving HCBS waiver services. MCOs community-based case managers are required to meet the same DHS TCM qualifications, requirements, and be accredited as specified in 441 Iowa Administrative Code Chapter 24 as listed above in this section.

☐ **Social Worker**
Specify qualifications:

☒ **Other**
Specify the individuals and their qualifications:

Integrated Health Homes, through their Care Coordinators, are responsible for service planning functions for those members enrolled with an IHH. IHH care coordinators must meet the requirements as outlined in the approved Health Home SPA Attachment H, SPMI: The Care Coordinator must be a BSW with an active license, or BS/BA in the related field.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Information related to waiver services and general waiver descriptions are initially made available following receipt of a waiver application. Service plans are then developed with the member and an interdisciplinary team, regardless of delivery system. Teams often consist of the member and, if appropriate, their representative; case manager or community-based case manager; service providers; and other supporting persons selected by the member. During service plan development, the member and/or their representative is strongly encouraged to engage in an informed choice of services, and is offered a choice of institutional or HCBS. Planning is timely, occurs when convenient for the member, and is intended to reflect the member's cultural considerations. If the member chooses to self-direct services, an Independent Support Broker is provided to assist with budgeting and employer functions.

The IME Member Services Unit remains available at all times, during normal business hours, to answer questions and offer support to all Medicaid beneficiaries. The IME MSU remains available to answer questions and offer support. Further, the MSU distributes a quarterly newsletter in effort to continually educate participants about services and supports that are available but may not have been identified during the service plan development process.

The fee-for-service person-centered planning processes must:

- Include people chosen by the member;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and
- Record the alternative home and community-based settings that were considered by the member.

MCOs are contractually required to provide supports and information that encourage members to direct, and be actively engaged in, the service plan development process, and to ensure that members have the authority to determine who is included in the process. Specifically, MCO person-centered planning processes must:
- Include people chosen by the member;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the member and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and
- Record the alternative home and community-based settings that were considered by the member.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-

centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

For fee-for-service members, service plans are developed by the member; DHS case manager and an interdisciplinary team. Planning meetings are scheduled at times and locations convenient for the member. The service plan must be completed prior to services being delivered and annually thereafter, or whenever there is a significant change in the member's situation or condition. The case manager receives the assessment and level of care determination from the IME Medical Services Unit. A summary of the assessment becomes part of the service plan. The case manager uses information gathered from the assessment and then works with the member to identify individual and family strengths, needs, capacities, preferences and desired outcomes and health status and risk factors. This is used to identify the scope of services needed.

Note: For both FFS and managed care enrollees, members age four years or older on the AIDS/HIV waiver are assessed using the interRAI assessment tool as identified in Appendix B-6-e. For children ages 0 - 3, the IME Medical Services unit uses the Case Management Comprehensive Functional Assessment Tool (Form 470-4694). For ages 4 – 20, the IME Medical Services unit uses the interRAI - Pediatric Home Care +(PEDS-HC), and for ages 21 to 64, the interRAI - Home Care (HC) to determine level of care. The interRAI is a Minimum Data Set screening tool that enables a trained assessor to assess multiple key domains of function, health, social support and service use. Particular interRAI HC items also identify persons who could benefit from further evaluation of specific problems of risks for functional decline. These are triggers that link the interRAI HC to a Clinical Assessment Protocol. The CAPS contain general guidelines for further assessment
The HC system supports a variety of research-informed decision support tools that assist the assessor in planning and monitoring care. These include:
*Scales for ADLs, cognition, communication, pain, depression, and medical instability
*Clinical Assessment Protocols that contain strategies to address problem conditions as triggered by one or more HC item responses
*Screening systems to identify appropriate outreach and care pathways for prospective clients (the MI Choice and MAPLe systems)
*A quality monitoring system (Home Care Quality Indicators, or HCQIs)
*A case-mix system that creates distinct service-use intensity categories (RUG-III/HC)

IME Medical Services may request additional information from the case manager or community-based case manager to clarify or supplement the information submitted with the assessment. The results of the assessment are used to develop the plan of care. Because the same criteria are used for both institutional care and waiver services, the outcome is reliable, valid, and fully comparable.
The case manager informs the member of all available non-Medicaid and Medicaid services including waiver services. There are waiver informational brochures available to share with members and their parents/guardians. Information is also available on the IME and MCO websites. The brochures include information on eligibility, service descriptions, and the application process. Once a member begins the enrollment process and has a case manager or community-based case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a member's plan of care.

The case manager or community-based case manager will also discuss with the member the self-direction option and give the member the option of self-directing services available. The member and the interdisciplinary team choose services and supports that meet the member's needs and preferences, which become part of the service plan. Service plans must:

-Reflect that the setting in which the member resides is chosen by the member;
-Reflect the member's strengths and preferences;
-Reflect the clinical and support needs as identified through the needs assessment;
-Include individually identified goals and desired outcomes which are observable and measurable;
-Include the interventions and supports needed to meet member's goals and incremental action steps as appropriate;
-Reflect the services and supports, both paid and unpaid, that will assist the member to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
-Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
-Include the identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
-Include a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications;
-Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when

needed;
-Include a plan for emergencies;
-Be understandable to the member receiving services and supports, and the individuals important in supporting the member;
-Identify the individual and/or entity responsible for monitoring the plan;
-Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;
-Be distributed to the member and other people involved in the plan;
-Indicate if the member has elected to self-direct services and, as applicable, which services the member elects to self-direct; and
-Prevent the provision of unnecessary or inappropriate services and supports.

The case manager or community-based case manager will be responsible for coordination, monitoring and overseeing the implementation of the service plan including Medicaid and non-Medicaid services. If a member chooses to self-direct, the member, with the help of a case manager identifies who will be providing Independent Support Broker Services.

For MCO members, service plans are developed through a person-centered planning process led by the member, with MCO participation, and representatives included in a participatory role as needed and/or defined by the member. Planning meetings are scheduled at times and locations convenient for the member. A team is established to identify services based on the member's needs and desires, as well as availability and appropriateness of services. The team is also responsible for identifying an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or when the member's needs change. Service plans are completed prior to services being delivered, and are reevaluated at least annually, whenever there is a significant change in the member's situation or condition, or at a member's request. Risk assessments and mitigation plans are completed during the member's service plan (ISP) team meeting. The community based case manager determines a members risk through a series of questions and answers. Findings are documented in the Person Centered Treatment Plan. This form guides the community based case manager to identify member's personal preferences for risk mitigation including back-up arrangements. The community based case manager leads the ISP meeting, ensuring that there is a back-up arrangement for each service identified. The member, ISP team, and ancillary providers receive a copy of the plan.

In accordance with 42 CFR 441.301 and 441 Iowa Administrative Code Chapters 90.5(1)b and 83, MCOs must ensure the service plan reflects the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan must reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports. The service planning process must address the full array of medical and non-medical services and supports provided by the MCO and available in the community to ensure the maximum degree of integration and the best possible health outcomes and member satisfaction. Services plans must:

-Reflect that the setting in which the member resides is chosen by the member;
-Reflect the member's strengths and preferences;
-Reflect the clinical and support needs as identified through the needs assessment;
-Include individually identified goals and desired outcomes which are observable and measurable;
-Include the interventions and supports needed to meet members' goals and incremental action steps as appropriate;
-Reflect the services and supports, both paid and unpaid, that will assist the member to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
-Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
-Include the identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
-Include a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications;
-Reflect risk factors and measures in place to minimize them, including individualized back- up plans and strategies when needed;
-Include a plan for emergencies;
-Be understandable to the member receiving services and supports, and the individuals important in supporting him or her;

-Identify the individual and/or entity responsible for monitoring the plan;
-Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;
-Be distributed to the member and other people involved in the plan;
-Indicate if the member has elected to self-direct services and, as applicable, which services the member elects to self-direct; and
-Prevent the provision of unnecessary or inappropriate services and supports.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the evaluation/reevaluation of level of care, risks are assessed for FFS members by a case manager and for MCO members by their respective MCO, using the assessment tools designated in B-6e. The assessment becomes part of the service plan and any risks are addressed as part of the service plan development process. The comprehensive service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. In addition, providers of applicable services shall provide for emergency backup staff. All service plans must include a plan for emergencies and identification of the supports available to the member in an emergency.

Emergencies are those situations for which no approved individual program plan exists and which, if not addressed, may result in injury or harm to the member or other persons or significant amounts of property damage.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

While information about qualified and accessible providers is available to members through the IME website, MCO website, and/or MCO Member Services call center, the case manager or community-based case manager first identifies providers to the member and their interdisciplinary team during the person-centered service planning process. Members are encouraged to meet with available providers before making a selection, and members are not restricted to choosing providers within their community. If an MCO is unable to provide services to a particular member using contract providers, the MCO is required to adequately and timely cover these services for that member using non-contract providers, for as long as the MCO's provider network is unable to provide them.

The MCOs are responsible for authorizing services for out-of-network care when they do not have an in-network provider available within the contractually required time, distance and appointment availability standards. The MCO is responsible for assisting the member in locating an out-of-network provider, authorizing the service and assisting the member in accessing the service. The MCO will also assist with assuring continuity of care when an in-network provider becomes available. To ensure robust provider networks for members to choose from, MCOs are not permitted to close provider networks until adequacy is fully demonstrated to, and approved by, the State. Further, members will be permitted to change MCOs in the event that their chosen provider does not ultimately contract with their MCO. Finally, MCOs are required to submit to the State on a regular basis provider network reports including, but not limited to network geo-access reports, 24- hour availability audit reports, provider-credentialing reports, subcontractor compliance summary reports, and provider helpline performance reports.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DHS has developed a computer program named the Individualized Services Information System (ISIS) to support HCBS programs. This system assists DHS with tracking information, monitoring, and approving service plans for fee-for-service participants. (Refer to appendix A and H for ISIS system processes.) On a monthly basis, the IME Medical Services Unit conducts service plan reviews. The selection size for the waiver has a 95% confidence level. This info is reported to CMS as part of Iowa's performance measures. ISIS will only be utilized for fee-for-service members and quality data for managed care participants will be provided by the MCOs.

The State retains oversight of the MCO service plan process through a variety of monitoring and oversight strategies as described in Appendix D – Quality Improvement: Service Plan section. On a monthly basis, each managed care organization conducts service plan reviews. The selection size for the waiver requires a 95% confidence level. The monthly info gathered by the MCOs is reported to the IME managed care Unit on a quarterly basis for review. The IME reviews the MCO service plan information and reports to CMS as part of Iowa's performance measures.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☒ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☒ **Other**

Specify:

DHS case managers, or health home coordinators maintain fee-for-service participant service plans. MCO community-based case managers maintain MCO member service plans.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the

implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

FFS
The case managers are responsible for monitoring the implementation of the service plan and the health and welfare of fee-for-service members, including:
- Monitoring service utilization including access and use of non-waiver services including health services.
- Making at least one contact per month with the member, the member's legal representative, the member's family, service providers, or another person, as necessary to develop or monitor the treatment plan.
- Make a face-to-face contact with the member at least once every three months.
- Participating in the development and approval of the service plan in coordination with the interdisciplinary team at least annually or as needs change. If services have not been meeting member needs, the plan is changed to meet those needs. The effectiveness of the emergency backup plan is also addressed as the service plan is developed.

The member is encouraged during the time of the service plan development to call the case manager or health home coordinator, if there are any problems with either Medicaid or non-Medicaid services. The case manager will then follow up to solve any problems. Monitoring service utilization includes verifying that:
- The member used the waiver service at least once a calendar quarter.
- The services were provided in accordance with the plan.
- The member is receiving the level of service needed.

The ISIS system is also used to assist with tracking information, monitoring services, and assuring services were provided to fee-for-service members. If the member is not receiving services according to the plan or not receiving the services needed, the member and other interdisciplinary team members and providers are contacted immediately.

The HCBS specialists (of the HCBS QIO Unit) monitor the how member health and welfare is safeguarded, the degree of service plan implementation; and the degree of interdisciplinary team involvement of the case manager, or health home coordinator during the HCBS Quality Assurance review. Members are asked about their choice of provider, whether or not the services are meeting their needs, whether staff and care coordinators are respecting their choice and dignity, if they are satisfied with their services and providers, or whether they feel safe where they receive services and live.

HCBS specialists also review the effectiveness of emergency back-up and crisis plans. These components are monitored through quality oversight reviews of providers, member satisfaction surveys, complaint investigation, and critical incident report follow-up. All providers are reviewed at least once over a five-year cycle and members are surveyed at a 95% confidence level. Information about monitoring results are compiled by the HCBS Quality Assurance and Technical Assistance Unit on a quarterly basis. This information is used to make recommendations for improvements and training.

The IME MSU also conducts quality assurance reviews of member service plans at a 95% confidence level. These reviews focus on the plan development, implementation, monitoring, and documentation that is completed by the case manager, CBCM, or health home coordinator. All service plans reviewed are assessed for member participation, whether the member needs are accurately identified and addressed, the effectiveness of risk assessments and crisis plans, member access to waiver and non-waiver services, as well as coordination across providers to best serve the member's needs. Information about monitoring results are compiled by the IME MSU on a quarterly basis. This information is used to make recommendations for improvements and training.

MCO
MCOs are responsible for monitoring the implementation of the service plans at a 95% confidence level. These reviews focus on the plan development, implementation, monitoring, and documentation that is completed by the case manager. All service plans reviewed are assessed for member participation, whether the member needs are accurately identified and addressed, the effectiveness of risk assessments and crisis plans, member access to waiver and non-waiver services, as well as coordination across providers to best serve the member's needs including access to waiver and non-waiver services, the quality of service delivery including access and use of non-waiver services including health services, and the health, safety and welfare of members and choice of service providers. Information about monitoring results are compiled and reported by the MCO on a quarterly basis. After the initiation of services identified in a member's service plan, MCOs monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan. At minimum, the care coordinator must contact members within five business days of scheduled initiation of services to confirm that services are being provided and that member's needs are being met. At a minimum, the community-based case manager shall contact 1915(c) HCBS waiver members at least monthly either in person or by telephone with an interval of at least fourteen (14) calendar days between contacts. Members shall be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at

least sixty (60) days between visits.

MCOs also identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively If problems are identified, MCOs complete a self-assessment to determine what additional supports, if any, could be made available to assist the member. MCOs must develop methods for prompt follow-up and remediation of identified problems; policies and procedures regarding required timeframes for follow-up and remediation must be submitted to DHS for review and approval. Finally, any changes to a member's risk are identified through an update to the member's risk agreement. MCOs must report on monitoring results to the State.

In the event of non-compliance with service plan timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues.

If the MCO fails to develop a plan of care for HCBS waiver enrollees within the timeframe mutually agreed upon between the MCO and the Agency in the course of Contract negotiations the MCO will be assessed a noncompliance fee of $315 per occurrence.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
SP-a1: The IME shall measure the number and percent of service plans that accurately reflect the member's assessed needs. The assessed needs must include, at a minimum, personal goals, health risks, and safety risks. Numerator = # of service plans that address all member assessed needs including health and safety risks, and personal goals. Denominator = # of reviewed service plans.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
person-centered plans and the results of the department approved assessment

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5% with 95% confidence level
☒ **Other** Specify: Contracted entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:
SP-c2: The IME will measure the number and percentof service plans which are

updated on or before the member's annual due date. Numerator = # of service plans updated prior to due date; Denominator = # of service plans reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
person-centered plans and the results of the department approved assessment.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5% with 95% confidence level
☒ **Other** Specify: Contracted entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP-c1: The IME will measure the number and percent of service plans which were revised when warranted by a change in the member's needs. Numerator = # of service plans updated or revised when warranted by changes to the member's needs. Denominator = # of reviewed service plans.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
person-centered plans and the results of the department approved assessmen

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

		+/- 5% with 95% confidence level
☒ **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:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope,***

amount, duration and frequency specified in the service plan.

Performance Measures

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

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

Performance Measure:
SP-d1: The IME will measure the # and percent of members' service plans that identify all the following elements: * amount, duration, and funding sources of all services * all services authorized in the service plan were provided as verified by supporting documentation. Numerator: # members receiving services authorized in their service plan; Denominator = # of service plans reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
The IPES survey is conducted at a 95% confidence level and responses recorded in a database. Data is pulled and inductively analyzed.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5% with 95% confidence level
☒ **Other** Specify: Contracted entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
SP-e2: The IME will measure the number and percentage of service plans from the HCBS QA survey review that indicated the member had a choice of providers.

Numerator: The total number of service plans reviewed which demonstrate choice of HCBS service providers; Denominator: The total number of service plans reviewed..

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
FFS QA review of service plan stored in OnBase. MCO review services plans available through their system.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5% with 95% confidence level
☒ **Other** Specify: Contracted entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP-e1: The IME will measure the number and percentage of members from the HCBS IPES who responded that they had a choice of services. Numerator = # of IPES respondents who stated that they were a part of planning their services; Denominator = # of IPES respondents that answered the question asking if they were a part of planning their services.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
FFS HCBS UNIT QA survey data and MCO IPES databases

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

		+/- 5% with 95% confidence level
☒ **Other** Specify: Contracted entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. MCOs are responsible for oversite of service plans for their members.

The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Iowa offers two self-direction services the Consumer Choices Option (CCO) and Consumer Directed Attendant Care (CDAC) service.

Consumer Choices Option (CCO)

The CCO offers both employer and budget authority to the member self-directing services. Members are given information about the CCO program at the initial person centered service plan meeting and at the subsequent annual service plan meetings thereafter. At the time of service plan development and/or at the member's request, the member has the option to convert the following ID Waiver services into an individualized self-direction budget based on services that are authorized in their service plan: (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; and (8) transportation.

CCO gives members control over a targeted amount of waiver dollars. Under CCO a member may convert specific waiver services that have been authorized in the member's service plan to create an individual monthly budget. Members that choose to use CCO will use the individual monthly budget to meet their assessed needs by directly hiring employees or purchase other goods and services. A member may use the following three types of self-direction services to meet their assessed needs: (1) self-directed personal care services; (2) self-directed community supports and employment; and (3) individual-directed goods and services.

CCO information is also available on the DHS website and has a dedicated CCO webpage.

Self-directed Community Supports and Employment are services that support the member in developing and maintaining life and community integration. Individual-directed goods and services are services, equipment or supplies not otherwise provided through the Medicaid State Plan that address an identified need in the member's service plan. The items or services would decrease the need for other Medicaid services, and/or promote inclusion in the community, and/or increase the member's safety in the community or home.

Members have authority over the individual authorized budget to perform the following tasks:
- contract with entities to provide services and support;
- determine the amount to be paid for services with the exception of the independent support broker and the financial management service whereas reimbursement rates are subject to the limits in 441 Iowa Administrative Code Chapter 79.1(2);
- schedule the provision for services;
- authorize payment for waiver goods and services identified in the individual budget; and
- reallocate funds among services included in the budget. Individual monthly budget development includes the costs of the FMS, ISB, and any services and supports chosen by the member as optional service components.

All members choosing CCO work with an ISB who will help them plan for their individual budget and services. The ISB works at the direction of the member and assists the member with their budget. The ISB is required to attend an ISB training prior working with members. The ISB cannot be the guardian, power of attorney, or a provider of service to the member, to avoid potential conflicts of interest. The ISB performs the following services as directed by the member or the member's representative:

- Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- Complete the required employment packet with the financial management service.
- Assist with interviewing potential employees and entities providing services and supports if requested by the member.

- Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- Assist the member with negotiating with entities providing services and supports if requested by the member.
- Assist the member with contracts and payment methods for services and supports if requested by the member.

• Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
• Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
• 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."

Members will also work with a Financial Management Service (FMS) provider that will receive Medicaid funds on behalf of the member. The FMS is the employer of record and performs all of the following services:

• Receive Medicaid funds in an electronic transfer.
• Process and pay invoices for approved goods and services included in the individual budget.
• Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
• Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
• Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
• Verify for the member an employee's citizenship or alien status.
• Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
o Verifying that hourly wages comply with federal and state labor rules.
o Collecting and processing timecards.
o 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.
o Computing and processing other withholdings, as applicable.
o Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
o Preparing and issuing employee payroll checks.
o Preparing and disbursing IRS Forms W-2 and W-3 annually.
o Processing federal advance earned income tax credit for eligible employees.
o Refunding over-collected FICA, when appropriate.
o Refunding over-collected FUTA, when appropriate.

• Assist the member in completing required federal, state, and local tax and insurance forms.
• Establish and manage documents and files for the member and the member's employees.
• 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.
• 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.
• Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
• Establish a customer services complaint reporting system.
• Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
• Develop a business continuity plan in the case of emergencies and natural disasters.
• Provide to the department an annual independent audit of the financial management service.
• Assist in implementing the state's quality management strategy related to the financial management service."

To determine the monthly CCO budget amount, a "cap amount" and "budget amount" are calculated by the Iowa Medicaid Enterprise (IME) for each waiver service that can be used in the CCO program. The calculations are does to assure cost neutrality of the CCO program, i.e., that using CCO will not cost more than using traditional service purchased from an enrolled HCBS service provider. Annually, the Department determines the average service cost by identifying the individual provider service costs as identified in the member service plans. The average service cost is used to determine the "cap amount" of the CCO budget. The cap amount for a service is considered what the service would cost if CCO was not being used and the service was included in the individual member service plan.
The cap amount is used to ensure the member stays within the program dollar cap limits within each waiver. This includes the monthly cap on the total services by waiver, e.g., the monthly cap on the Brain Injury or Physical Disability Waivers. The waiver program cap limits are also applied to services specific cost limits, e.g., the monthly cap on

supported employment services costs. The ID Waiver does not have total services monthly cap, but does have limits on the amount of supported Employment and home and vehicle modifications that are available for use. The service specific limits are identified in the service descriptions in Appendix C.

The department also determines the percentage of services that are used, compared to what is authorized within a waiver service plan. This is done to identify the average amount of services that are authorized in a service plan but not used. The IME calculates this by comparing the amount of service that is authorized in each member service plan to the amount of the service that is billed in the MMIS system. This percentage is applied to the service cap amount to determine the CCO "budget amount". The budget amount is the total funds available to the member in the monthly CCO budget for the member to manage.

The member may choose to set aside a certain amount of the budget each month to save towards purchasing additional goods or services they cannot buy from the normal monthly budget. A savings plan must be developed by the member, and approved by DHS prior to implementation. The good or service being saved for must be an assessed need identified in the member's service plan.

Consumer Directed Attendant Care (CDAC)

The CDAC service began in Iowa in 1996 and was the first attempt by the State to offer self-directed services. CDAC is a self-directed service that offers the member employer authority only. There are two CDAC services—skilled and unskilled. See Appendix C for service description and provider qualifications. All CDAC providers are enrolled Medicaid providers, and may be an individual employee or an agency. There are no FMS or ISB services to support the CDAC service and the enrolled CDAC provider performs all billing through the Medicaid MMIS systems. The IME Provider Services Unit has dedicated staff available to address CDAC issues and support the Individual CDAC provider with billing. The member's case manager is available to support the member when using CDAC services. The member is responsible for completing the CDAC agreement with the CDAC provider. The CDAC agreement identifies the personal care services that will be performed. The member is responsible for hiring, directing, and supervising the CDAC provider to assure their identified needs are being met. Members are also responsible for signing CDAC timecards to allow payment for services.
Nonskilled CDAC services are limited to help with activities such as dressing bathing, personal hygiene, toileting, meal preparation, etc. A full description of CDAC supports are listed in Appendix C.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☒ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Self-direction training and outreach materials are available through the IME website and MCOs. Materials include information on the benefits, responsibilities, and liabilities of self-direction. A brochure about this option has been developed and includes information about the benefits, responsibilities, and liabilities. This brochure is available at all the local DHS offices, the DHS website, and has been distributed to other community agencies. The participant may also call IME Member Services and request to have the brochure mailed directly to them. All participants must sign an informed consent contract and a risk agreement that permits the participant to acknowledge and accept certain responsibilities for addressing risks.

The service worker, case manager, health home coordinator, or community-based case manager is required to discuss this option along with the benefits, responsibilities and liabilities at the time of the service plan development and/or any time the participant's needs change. This results in information about participant direction activities being reviewed, at least annually, with the participant. This option is intended to be very flexible; participants can choose this option at any time. Once given information about this option, the participant can immediately elect this option, or can elect to continue or start with traditional services initially and then change to self-direction at a later date.

MCOs must also provide ongoing participant or representative training upon request and/or if it is determined a member needs additional training. Training programs are designed to address the following: (i) understanding the role of participants and/or representatives in self-direction; (ii) selecting and terminating providers; (iii) being an employer and managing employees; (iv) conducting administrative tasks such as staff evaluations and approval of time sheets; (v) scheduling providers; and (vi) back-up planning. All MCO training and education materials are subject to review and approval by the State.

To give the participant an opportunity to locate providers and supports, the service plan can reflect that traditional services will begin at the start date of the service plan and the self-directed services and supports will begin at a later date. This does not require a change in the service plan. Participants can elect self-direction and then elect to go back to traditional services at any time. The service worker, case manager, health home coordinator, or community-based case manager is responsible for informing the participant of their rights and responsibilities. All self-directed services and supports must begin on the first of a month.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Services may be self-directed by a non-legal representative freely chosen by an adult participant. The policies described in this section apply to both the fee-for-service and managed care delivery systems. If the participant selects a non-legal representative, the representative cannot be a paid provider of services and must be eighteen years or age or older. The participant and the representative must sign a consent form designating who they have chosen as their representative and what responsibilities the representative will have. The choice must be documented in the participant's file and provided to the participant and their representative. At a minimum, the representative's responsibilities include ensuring decisions made do not jeopardize the health and welfare of the participant and ensuring decisions made do not financially exploit the participant.

The IME uses a quality assurance process to interview participants in order to determine whether or not the representative has been working in their best interest. The interviews are completed primarily by telephone and may be completed in-person if requested. The interviews are conducted as an ongoing QA activity and are used to ensure that participants' needs are met and that services are provided. QA interviews are completed monthly with a randomly selected representative sample of participants. The interview sample selection size assures a 95% confidence level in the results of the interviews.

In addition, the Independent Support Broker provides monitoring of health and safety. The participant's service worker, case manager, or health home coordinator is responsible to assess individual needs and monitor service delivery to assure that the participant's health and safety are being addressed. Service workers, case managers, and health home coordinators routinely review how services are being provided and monitor services to assure the participant's needs are being met, including how the representative is performing.

MCOs are contractually required to maintain quality assurance processes to ensure that the representative functions in the best interest of the participant. These quality assurance processes are subject to DHS review and approval and include, but are not limited to, monthly member interviews, to assess whether a non-legal representative is working in the best interest of the member. DHS provides additional oversight in accordance with the HCBS quality improvement strategy.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Self Directed Community Support and Employment	☒	☒
Individual Directed Goods and Services	☒	☒
Consumer Directed Attendant Care - Skilled	☒	☐
Homemaker	☒	☒
Home Delivered Meals	☒	☒
Self Directed Personal Care	☒	☒
Independent Support Broker	☒	☒
Respite	☒	☒
Consumer-Directed Attendant Care - Unskilled	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial

transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Entities providing FMS must be cooperative, not-for-profit member owned and controlled, federally insured financial institution that is and charged by either the National Credit Union Administration or the Credit Union Division of the Iowa Department of Commerce. The FMS must successfully pass a readiness review of certification by DHS or a financial institution charted by the Office if the Comptroller of the Currency, a Bureau of the United States Department of the Treasury, is a member of the Federal Reserve; and/or is federally insured by the Federal Deposit Corporation. Further, the entity must be enrolled as a Medicaid provider. Once enrolled and approved as a Medicaid provider, the FMS will receive Medicaid funds in an electronic transfer and will pay all service providers and employees electing the self-direction option.

MCOs are responsible for contracting with an FMS entity or entities to assist members who elect to self-direct. All MCO contracted FMS entities must meet the requirements documented in this section. Under the managed care delivery system, the FMS entity contracted with the MCO is responsible for the same functions as under the fee-for-service model.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS entities are paid a monthly fee for their services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

IME provides oversight of the FMS entities and monitors their performance yearly. Oversight is conducted through an annual self-assessment, and an on-site review completed by DHS or by a designated IME unit. As noted above, FMS entities must also be enrolled as Medicaid providers. The MCOs are required to mirror this oversight process for their FMS entities and the IME reviews for compliance and monitors outcomes.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The case manager or community-based case manager provides the waiver member with information and assistance with choosing the CCO program or CDAC service as part of the person centered service planning process. The case manager or community-based case manager also assists the member in locating an Individual Support Broker to assist with the planning and managing a monthly CCO budget and is responsible for monitoring the delivery of goods and services as identified in the service plan.

The CCO program provide case managers, community-based case managers, and ISB's with information on understanding and implementing the CCO program. The information identifies self-direction issues that have been identified through quality assurance activities.

The CDAC service began in Iowa in 1996 and was the first attempt by the State to offer self-directed services. CDAC is a self-directed service that offers the member employer authority only. There are two CDAC services—skilled and unskilled. See Appendix C for service description and provider qualifications. All CDAC providers are enrolled Medicaid providers, and may be an individual employee or an agency. There are no FMS or ISB services to support the CDAC service, and the enrolled CDAC provider performs all billing through the Medicaid MMIS systems. The member is responsible for completing the CDAC agreement with the CDAC provider. The CDAC agreement identifies the personal care services that will be performed. The member is responsible for hiring, directing, and supervising the CDAC provider to assure their identified needs are being met. Members are also responsible for signing CDAC timecards to allow payment for services.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Financial Management Services	☒
Self Directed Community Support and Employment	☐
Individual Directed Goods and Services	☐
Home Health Aide	☐
Consumer Directed Attendant Care - Skilled	☐
Counseling	☐
Homemaker	☐
Home Delivered Meals	☐
Self Directed Personal Care	☐
Independent Support Broker	☒
Nursing	☐
Adult Day Care	☐
Respite	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Consumer-Directed Attendant Care - Unskilled	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Through a contract with the Iowa Medicaid Enterprise (IME) the HCBS Quality Assurance and Technical Assistance Unit provides support and assistance to service workers, case managers, health home coordinators, community-based case managers, members, providers, ISBs, and others needing information about HCBS waiver programs. This includes the self-direction program. The technical assistance provided includes developing and conducting regularly scheduled webinar trainings, developing and implementing required ISB training and answering questions from the field about the CCO program.

The Quality Assurance and Technical Assistance contract is procured through a competitive bidding process. A request for proposal is issued every three years to solicit bids. The RFP specifies the scope of work to be completed by the contractor. The RFP process also includes a pricing component to assure that the contractor is reimbursed in an amount that assures performance outcomes are achieved in a cost effective manner.

The Quality Assurance and Technical Assistance contract is managed by an IME state employee. This employee acts as the contract manager and manages the day-to-day operations of the contract to assure compliance with the performance outcomes of the contract. Contract reports are received by the IME monthly, quarterly and annually on the performance measures of the contract. Any performance issues that arise are addressed with the Quality Assurance and Technical Assistance Unit contract manager to make corrections and improve performance.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Members may receive traditional waiver services, as well as services and supports under an individual budget for self-direction. Any waiver member may voluntarily discontinue the self-direction option at any time, regardless of delivery system (FFS members or MCO members). The member will continue to be eligible for services as specified in the service plan, regardless of whether they select the self-direction option. When CCO is discontinued or the CCO services are voluntarily reduced, a new service plan will be developed to authorize needed services that will be provided through an enrolled ID Waiver provider (vs. the CCO program). The case manager or community-based case manager will work with the member to ensure that a current service plan is authorized and services are in place and service continuity is maintained.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

For fee-for-service enrollees, DHS service workers, case managers, or health home coordinators will terminate use of the self-direction option any time there is substantial evidence of Medicaid fraud or obvious misuse of funds. Involuntary termination can also occur if the service worker, case manager, or health home coordinator is not able to verify the types of services provided and the outcome of those services. If the participant and their representative are both found unable to self-direct, the participant will be transitioned to regular waiver services. The participant has the right to appeal any adverse action taken by the service worker, case manager, or health home coordinator to terminate self-directed services and is subject to the grievance and appeals protections outlined in Appendix F. The service worker, case manager, or health home coordinator will develop a new service plan and assure alternative services are in place to maintain service.

MCOs may only initiate involuntarily termination of a member’s use of the self-direction option if there is evidence of Medicaid fraud or misuse of funds, or if the MCO determines there is a risk to the member’s health or safety. Under these conditions, MCOs are required to submit a request to DHS for review and approval to involuntarily terminate. Requests must contain sufficient documentation regarding the rationale for termination. Upon DHS approval, MCOs must notify the member and facilitate a seamless transition to traditional waiver services to ensure there are no interruptions or gaps in service delivery.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		5
Year 2		5
Year 3		5
Year 4		5
Year 5		5

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Pursuant to Iowa Code 249A.29 and Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), all providers of HCBS waiver services must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant. The State pays for the first background check of workers who provide waiver services to fee-for-service participants. If a second background check is completed, it is the responsibility of the employee to pay for the background check. MCOs are responsible for the costs of investigations of workers who provide waiver services to members.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Same as C-2-a above.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the state's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Under the traditional service model for the waiver, the member chooses a service provider from a list of providers who are enrolled with Iowa Medicaid. The case manager or health home coordinator and member work together to detail the tasks and goals for the provider. After service provision, the provider submits a claim to the IME where the claim is adjudicated in accordance with IME protocols.

Under the self-direction option, a member is not limited to the providers who have enrolled with Iowa Medicaid. The member is considered the employer and can choose any individual that they feel is qualified to provide the needed service. Members create support plans, make provider and service choices, select and employ staff, and monitor the quality of support services. MCOs are responsible for assisting the member with quality assurance activities and monitoring the quality of services provided. MCO plans to accomplish this contractual requirement are subject to DHS review and approval. Members determine the wages to be paid to the provider and the units of service (limited by the self-direction budget). Interviewing, hiring, scheduling, and firing is done by the member. Claims are submitted to the FMS for processing for payment.

Each member who chooses to self-direct their services will continue to have a traditional service plan developed that is based on the level of care assessment and need of the member. If a member has a need for the services that can be included in the individual budget and they choose to self-direct one or all of those services, then the individual budget amount is determined by the amount of service that was authorized for those services under the traditional service plan. The level of need is determined by the level of care determination made by IME MSU; the supports needed and the amount of supports needed are determined by a review of the assessment made by the case manager, CBCM, or health home coordinator prior to the member selecting the self-direction option. Members who reside in an assisted living facility may also choose to self-direct some of their services. Specifically, the member can choose to self-direct services not provided by the facility (i.e., vehicle modification) or can choose another provider for services that are optional from the facility (i.e., meals or housekeeping).

Historically, members do not use 100% of their authorized waiver services. To ensure that the State or MCO does not spend more than what is historically spent for traditional waiver services, each service authorized under self-direction will have a utilization adjustment factor applied to it. This utilization adjustment factor is determined by an analysis of what percentage of authorized services has historically been used for each service on an aggregate by all members enrolled in that particular waiver who have accessed that particular service. The utilization factor is not based upon individual member usage, but on historical percentage usage of authorized services by all members enrolled in the waiver who have accessed that particular service. A member new to the waiver or new to self-direction would have the same utilization factor applied as all other waiver members who are self-directing services. The utilization adjustment factor will be analyzed, at a minimum, every 12 months and adjusted as needed based historical use. This method will be used for all waiver members choosing the self-direction option. Members are notified of the budget methodology and limits at the time they receive the CCO Booklet, during their service plan is development and by the Independent Support Broker hired to assist the individual to develop the budget. The individual budget methodology is stated in the 441 Iowa Administrative Code Chapter 78.41(15). In addition, this information is shared during all outreach and training held throughout the State for members, families, and other advocates. The MCOs are also responsible for making the budget methodology available to members through their case managers and member communication materials.

The following is an example of how an individual budget is determined:

A member has a need for a particular service. On their traditional service plan they are authorized 10 units of service at $20 a unit. That member decides that they would like to self-direct their services. The amount authorized is $200 in the traditional service plan. A utilization adjustment factor of 80% is applied. The member’s individual budget amount then becomes $160 ($200 X 80%). The 20% reduction (100% authorization minus 80% actual utilization for a service) is applied to allow for cost neutrality between the service under the traditional waiver plan and self-direction. If the average service utilization is only 80% of an authorized service under the traditional waiver, then a self-directed member is limited to that same 80% to preserve cost neutrality. The total monthly cost of all services (traditional and self-directed services) cannot exceed the established aggregate monthly cost of the traditional services authorized.

If there is a need that goes beyond the budget amount and/or the waiver service limit, the member has the right to request an exception to policy. Exceptions to policy may be granted to the requestor when the member has needs beyond the limits expressed in the Iowa Administrative Code. For fee-for-service members this decision is made

by the Director of DHS, based on an evaluation of the member's needs in relation to the State's necessity to remain within the waiver's parameters of cost neutrality. The process to request an exception is shared on the DHS website as well as with the member when they apply for waiver services. In addition, any member has the right to appeal any decision made by DHS and to request an appeal hearing by an administrative law judge. The member is afforded the opportunity to request a fair hearing when the budget adjustment is denied or the amount of budget is reduced as described in F-1.

The MCOs operate an exception to policy process for their members. In the event an MCO denies an exception to policy and determines the member can no longer have his or her needs safely met through the 1915(c) waiver, the MCO is required to forward this information to DHS. In addition, MCO members have the right to appeal any decision made by the MCO and may appeal to the DHS once the MCO appeals process has been exhausted as described in F-1.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Members, regardless of delivery system (i.e., FFS members and MCO members) will be informed of their budget amount during the development of the service plan. The member can then make a final decision as to whether they want the self-direction option. If a member needs an adjustment to the budget, the member can request a review of the service plan.

As noted above, if there is a need that goes beyond the budget amount and/or the waiver service limit, the member has the right to request an exception to policy. In addition, any member has the right to appeal any decision. The member is afforded the opportunity to request a fair hearing when the budget adjustment is denied or the amount of budget is reduced as described in F-1.

MCO enrollees have the right to a State Fair Hearing after exhausting the MCO appeals process. It is the responsibility of the health home coordinator, case manager, and community based case manager to inform the member of the budget amount allowed for services before the service plan is completed.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

or both fee-for-service and MCO members, once the monthly budget amount has been established, the member will develop a detailed monthly budget that identifies the goods and services that will be purchased and the employees that will be hired to meet the assessed needs of the member. This budget amount is the same amount whether the member utilizes only traditional waiver services, utilizes only self-directed services, or uses a combination of traditional and self-directed services. All services under the waiver add into the one budget and that budget maximum is determined by the member's level of care and not by the type of services accessed by the member.

Once the monthly budget amount has been established, the member will develop a detailed monthly budget that identifies the goods and services that will be purchased and the employees that will be hired to meet the assessed needs of the member. The budget is sent to the FMS to identify what goods and services are approved for purchase and the employees that will be submitting timecards to the FMS for payment. The member can modify services and adjust dollar amounts among line items in the individual budget without changing the service plan as long as it does not exceed the authorized budget amount. They must submit a new budget to the FMS that identifies the changes. The FMS must receive all modifications to the individual budget within the month when the changes occur and will monitor the new budget to assure the changes do not exceed the authorized budget amount. The Individual Support Broker and the FMS will both monitor to assure expenses are allowable expenses.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

When members choose self-direction they sign a consent form that explains their rights and responsibilities, including consequences for authorizing payments over the authorized budget amount.

Members are responsible to monitor their own plans, and are responsible for the consequences. One of the statements from Form 470-4289 Informed Consent and Risk Agreement states: "I understand that if I overspend my budget and no longer have funds in my Individual budget, I am personally responsible to pay my employees and to pay for my purchases."

Self-directed service utilization is monitored by the member's case manager or community based case manager quarterly to assure it continues to meet the needs of the member. At least annually and or more frequently as needed by the member. An annual service plan review is conducted to review all services that were authorized in the previous year to assure they require continued authorization. The case manager or community based case manager has access to self-directed service utilization of the member in the previous year and may reduce the amount of services if it is determined that the member was not fully using the services as authorized.

The following safeguards are in place to prevent premature depletion of participant budget:
• The case manager and member or legal representative work together to create a service plan addressing person centered needs.
• The member selects services to be self-directed. This information is included in the service plan.
• The case manager authorizes services in the service plan.
• The member or legal representative the signs service plan to indicate agreement with the plan.
• The case manager identifies the CCO budget amount and provides the amount to the member or legal representative and Independent Support Broker (ISB).
• The member and the ISB complete the CCO budget on the budget sheet, form 470-4431. The budget amount on the budget sheet cannot exceed the amount
approved by the case manager in the service plan
• The member or legal representative signs the budget sheet to indicate understanding and agreement.
• The budget sheet is forwarded to the FMS prior to the month of service identified on the budget.
• The FMS staffs a call center to respond timely to member, legal representative and ISB questions about processes and remaining budget balances.
• The FMS verifies that the amount included on the budget form does not exceed the authorized budget amount.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

FEE FOR SERVICE:
Members are given an oral explanation of the appeals (State Fair Hearing) process during the application process by the Iowa Department of Human Services (DHS) income maintenance staff. The Department also gives members an oral explanation at the time of any contemplated adverse benefit determination. Depending on the adverse benefit determination, this could be provided by the income maintenance worker, case manager, integrated health care coordinator, community-based case manager, and/or medical provider performing the level of care determination. The member is also given written notice of the following at the time of application; and at the time of any department adverse benefit determination. An adverse benefit determination affects a claim for assistance in which applicants are not provided the choice of home and community based services as an alternative to institutional care and members are denied services or providers of their choice, or whose services are denied, suspended, reduced or terminated.

An adverse benefit notice of determination that results in members' right to appeal includes the following elements: the right to request a hearing, the procedure for requesting a hearing, the right to be represented by others at the hearing, unless otherwise specified by the statute or federal regulation, provisions for payment of legal fees by DHS; and how to obtain assistance, including the right to continue services while an appeal is pending.

The choice of HCBS vs. institutional services is discussed with the member at the time of the completion of the application by DHS income maintenance staff; and again at the time of the service plan development by the case manager or community-based case manager. The responsibility to explain the right to request a State Fair Hearing for choice between institutional care vs. HCBS is the responsibility of the state's Income Maintenance Worker at the time of waiver application.

All DHS application forms, notices, pamphlets and brochures contain information on the appeals process and the opportunity to request an appeal. This information is available at all of the local offices and on the DHS website. The process for filing an appeal can be found on all Notices of Decision (NOD). Procedures regarding the appeal hearing can be found on the Notice of Hearing. As stated in Iowa Administrative Code, any person or group of persons may file an appeal with DHS concerning any decision made. The member is encouraged, but not required, to make a written appeal on a standard Appeal and Request a Hearing form. Appeals may also be filed via the DHS website. If the member is unwilling to complete the form, the member would need to request the appeal in writing.

All notices are kept at all local DHS Offices or the case manager or community-based case manager's file. The member is given their appeal rights in writing, which explains their right to continue with their current services while the appeal is under consideration. Copies of all notices for a change in service are maintained in the service file. IME reviews this information during case reviews.

MANAGED CARE ORGANIZATIONS:

When an HCBS member is assigned to a specific MCO, the assigned MCO community based case manager explains the member's appeal rights through the Fair Hearing process during the initial intake process. The responsibility to explain the right to request a State Fair Hearing for choice between institutional care vs. HCBS is the responsibility of the state's Income Maintenance worker at the time of waiver application; this action is not the responsibility of the MCO.

The MCOs keep the notifications as indicated here:
Amerigroup: Notices are sent to requesting provider, member, and a copy is stored in online member medical record file.
Iowa Total Care: Notices of adverse action (which outline a member's rights to Fair Hearing) are housed within specified documentation storage systems based on service/case type. These systems include: Linx, ECAA, and ETS.

In accordance with 42 CFR 438, an adverse benefit determination means any of the following:
(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
(2) The reduction, suspension, or termination of a previously authorized service.
(3) The denial, in whole or in part, of payment for a service.
(4) The failure to provide services in a timely manner, as defined by the State.
(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

In accordance with 42 CFR 438, an appeal means a review by an MCO of an adverse benefit determination that it has issued.

MCOs give their members written notice of all adverse benefit determinations, not only service authorization adverse benefit determinations, in accordance with state and federal rules, regulations and policies, including but not limited to 42 CFR 438. MCO enrollment materials must contain all information for appeals rights as delineated in 42 CFR 438.10, including: (A) the right to file an appeal; (B) requirements and timeframes for filing an appeal; (C) the availability of assistance in the filing process; (D) the right to request a State Fair Hearing after the MCO has made a determination of a member's internal MCO appeal which is adverse to the member. The fact that, if requested by the member, benefits that the MCO seeks to reduce or terminate will continue if the member files an appeal or requests a State fair hearing within the specified timeframe and that the member may be required to pay the cost of such services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the member.

MCOs must provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to providing interpreter services, and toll-free numbers that have adequate TTY/TTD and interpreter capability. Upon determination of the appeal, the MCO must ensure there is no delay in notification or mailing to the member and member representative the appeal decision. The MCO's appeal decision notice must describe the adverse benefit determinations taken, the reasons for the adverse benefit determination, the member's right to request a State fair hearing, process for filing a fair hearing and other information set forth in 42 CFR 438.408(e).

MCOs must maintain an expedited appeals process when the standard time for appeal could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain or regain maximum function. The MCO must also provide general and targeted education to members and providers regarding expedited appeals including when an expedited appeal is appropriate and procedures for providing written certification thereof.

The MCO's appeal process must conform to the following requirements:

– Allow members, or providers acting on the member's behalf, sixty (60) calendar days from the date of adverse benefit determination notice within which to file an appeal.
– In accordance with 42 CFR 438.402, ensure that oral requests seeking to appeal an adverse benefit determination are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.
– The MCO must dispose of expedited appeals within 72 hours after the Contractor receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c).
– In accordance with 42 CFR 438.410, if the MCO denies the request for an expedited resolution of a member's appeal, the MCO must transfer the appeal to the standard thirty (30) calendar day timeframe and give the member written notice of the denial within two (2) calendar days of the expedited appeal request. The MCO must also make a reasonable attempt to give the member prompt oral notice.
– The MCO must acknowledge receipt of each standard appeal within three (3) business days.
– The MCO must make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 CFR 438.408. If the timeframe is extended, for any extension not requested by the member, the MCO must give the member written notice of the reason for the delay.
– In accordance with 42 CFR 438.408, written notice of appeal disposition must be provided with citation of the Iowa Code and/or Iowa Administrative Code sections supporting the adverse benefit determination in non-authorization and care review letters that advise members of the right to appeal. For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice. The written notice of the resolution must include the results of the resolution and the date it was completed. For appeals not resolved wholly in favor of the member, the written notice must include the right to request a State fair hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. The MCO shall direct the member to the Agency Appeal and Request for Hearing form as an option for submitting a request for an appeal. This shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds the Contractor's adverse benefit determination.

Members enrolled with an MCO must exhaust the MCO's internal grievance processes before pursuing a State Fair Hearing. This requirement is outlined in the concurrent §1915(b) waiver, Part IV, Section E.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Each MCO operates its own internal grievance and dispute resolution processes. In accordance to 42 CFR 438.408(f), a managed care enrollee may request a State Fair Hearing only after receiving notice that the MCO is upholding the adverse benefit determination.

The policies and procedures regarding the MCO grievance and appeals system are outlined in the concurrent §1915(b) waiver, Part IV, Section E. MCO members can appeal any adverse benefit determination within 60 calendar days. An adverse benefit determination is defined as the: (i) denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) reduction, suspension or termination of a previously authorized service; (iii) denial, in whole or in part, of payment for a service; (iv) failure to provide services in a timely manner; (v) failure of the MCO to act within the required timeframes; or (vi) the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities. MCOs must ensure that oral requests seeking to appeal an adverse benefit determination are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution. MCOs must make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 C.F.R. § 438.408. Expedited appeals must be disposed within seventy-two (72) hours unless the timeframe is extended pursuant to 42 CFR § 438.408 and 410. MCO members can also file grievances with their MCO; grievances are any written or verbal expression of dissatisfaction about any matter other than an adverse benefit determination." MCO members have the right to request a State Fair Hearing if dissatisfied with the outcome of the MCO appeals process. MCOs notify members of this right through enrollment materials and notices of adverse benefit determination, including information that the MCO grievance and appeals process is not a substitute for a Fair Hearing. MCOs must acknowledge receipt of a grievance within three (3) business days and must make a decision on grievances and provide written notice of the disposition of grievance within thirty (30) calendar days of receipt of the grievance or as expeditiously as the member's health condition requires. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 C.F.R. § 438.408.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

FEE FOR SERVICE:
IME is responsible for operation of the complaint and grievance reporting process for all fee-for-service members. In addition, the Department maintains an HCBS Quality Assurance and Technical Assistance Unit contract that is responsible for the handling of fee-for-service member complaints and grievances in regards to provision of services under this waiver.

MANAGED CARE ORGANIZATION:

IME Member Services MCO Member and MCO Liaison: Designated IME Member Services staff serves as a liaison for any MCO grievance/complaint that is reported to IME Policy staff by an MCO member or his/her advocate. IME Policy sends the pertinent details of the grievance/complaint to the MCO liaison. The IME MCO liaison communicates and coordinates with the MCO and member to grievance/complaint to resolution; and, the resolution is communicated to the IME Policy staff who received the original grievance/complaint. This process serves to support those MCO members who may be confused about the MCO grievance/complaint process to follow or members who have not been able to resolve their grievance/complaint with their MCOs.

Grievances/complaints follow the parameters and timelines in accordance with 42 CFR 438.408 and 438.410.

A grievance/complaint means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision.

MCO Grievance/Complaint System:
The MCO must provide information about its grievance/complaint system to all providers and subcontractors at the time they enter into a contract. Further, the MCO is responsible for maintenance of grievance records in accordance with 42 CFR 438.416.

The MCO must provide information about its grievance/complaint system to all members and provide reasonable assistance in completing forms and taking procedural steps. This responsibility also includes; but is not limited to, auxiliary aids and services upon request (e.g. interpreter services and toll–free numbers that have TTY/TTD and interpreter capability).

The MCO member handbook must include information, consistent with 42 CFR 38.10.

The MCO must insure that individuals who make decisions on grievances have not been involved in any previous level of review or decision-making and is not a subordinate of such individual.

MCO Grievance/Complaint Process:
A member may submit an oral or written grievance at any time to the MCO. With written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. There is not a timeline for submission.

The MCO must acknowledge receipt of the grievance.

The MCO must process the grievance resolution within 30 days of the date that the grievance is received and issue a written notification to the member in accordance with 42 CFR 438.408.

The resolution may be extended by fourteen (14) days upon member request. If the member does not request an extension, the MCO must make reasonable efforts to give the member prompt oral notice of the delay; and within two (2) calendar days provide the member with a written notice of the basis for the decision to extend the timeframe. If the member does not agree with the extension, he/she may file an additional grievance to the extension.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available

to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Any fee-for-service waiver member, member's relative/guardian, agency staff, concerned citizen or other public agency staff may report a complaint regarding the care, treatment, and services provided to a member. A complaint may be submitted in writing, in person, by e-mail or by telephone. Verbal reports may require submission of a detailed written report. The complaint may be submitted to an HCBS Provider Quality Oversight Specialist, HCBS Program Manager, any IME Unit, or Bureau Chief of Long Term Care. Complaints by phone can be made to a regional HCBS Provider Quality Assurance Oversight Specialist at their local number or by calling the IME. The Bureau of Long Term Care has established a committee to review complaints. The committee will meet biweekly to review current complaints.

Once received, the HCBS Quality Assurance and Technical Assistance Unit shall initiate investigation within one business day of receipt and shall submit a findings report to the Quality Assurance Manager within 15 days of finalizing the investigation. Once approved by the Quality Assurance Manager, the findings report is provided to the complainant and the provider in question. If the complainant is a member, they are informed by the HCBS Quality Assurance and Technical Assistance Unit Incident and Complaint Specialist that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing.

MCO members must exhaust the entity's internal grievance and appeals processes before pursuing a State Fair Hearing. The policies and procedures regarding the MCO grievance and appeals system are outlined in the concurrent §1915(b) waiver, Part IV, Section E. MCO members can appeal any "action" within 60 days. An "action" is defined as the: (i) denial or limited authorization of a requested service, including the type or level of service; (ii) reduction, suspension or termination of a previously authorized service; (iii) denial, in whole or in part, of payment for a service; (iv) failure to provide services in a timely manner; or (v) failure of the MCO to act within the required timeframes set forth in 42 CFR 438.408(b). In accordance with 42 CFR 438.406, oral requests seeking an appeal are treated by the MCO as an appeal; however, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.

MCO members have the right to request a State Fair Hearing if dissatisfied with the outcome of the MCO appeals process. MCOs notify members of this right through enrollment materials and notices of action. In accordance with 42 CFR 438.406, the MCO provides the member and their representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents or records considered during the appeals process. In addition, the member and their representative have the opportunity to present evidence and allegations of fact or law in person as well as in writing. Upon determination of the appeal, the MCO must promptly notify the member and his/her representative of the appeal decision. The MCO's appeal decision notice must describe the actions taken, the reasons for the action, the member's right to request a State Fair Hearing, process for filing a Fair Hearing and other information set forth in 42 CFR 438.408(e).

MCOs must ensure that the individuals rendering decisions on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with appropriate clinical expertise in treating the member's condition or disease if the decision will be in regard to any of the following: (i) an appeal of a denial based on lack of medical necessity; (ii) a grievance regarding denial of expedited resolution of an appeal; or (iii) any grievance or appeal involving clinical issues. Appeals must be resolved by the MCO within 30 calendar days of receipt; this timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c).

MCOs must resolve appeals on an expedited basis when the standard time for appeal could seriously jeopardize the member's health or ability to maintain or regain maximum function. Such expedited appeals must be resolved within 72 hours after the MCO receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c). Standard appeals must be resolved within 30 calendar days; this timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c). If the timeframe is extended, for any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay. Within 90 calendar days of the date of notice from the MCO on the appeal decision, the member may request a State Fair Hearing.

MCO members can also file grievances with their MCO; grievances are any written or verbal expression of dissatisfaction about any matter other than an "action," as defined above. Grievances may be filed either orally or in writing; receipt is acknowledged by the MCO within 3 business days and resolved within 30 calendar days or as expeditiously as the member's health condition requires. This timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c).

MCOs are required to track all grievances and appeals in their information systems; this includes data on clinical reviews,

appeals, grievances and complaints and their outcomes. MCOs are responsible for reporting on grievances and appeals to DHS. This includes maintenance and reporting to the State the MCO member grievance and appeals logs which includes the current status of all grievances and appeals and processing timelines.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All waiver service providers, case managers, and MCO community based case managers (CBCMs), regardless of delivery system (i.e., FFS or managed care), are required to document major and minor incidents and make the incident reports and related documentation available to DHS upon request. Providers, case managers, and MCO CBCMs must also ensure cooperation in providing pertinent information regarding incidents as requested by DHS. MCOs must require that all internal staff and network providers report, respond to, and document major incidents, as well as cooperate with any investigation conducted by the MCO or outside agency, all in accordance with State requirements for reporting incidents for 1915(c) HCBS Waivers, 1915(i) Habilitation Program, PMICs, and all other incidents required for licensure of programs through the Department of Inspections and Appeals.

Per Chapter 441 Iowa Administrative Code 77.25(1), “major incidents” are defined as an occurrence involving a participant during service provision that: (1) results in a physical injury to or by the participant that requires a physician’s treatment or admission to a hospital;
(2) results in the death of any person;
(3) requires emergency mental health treatment for the participant;
(4) requires the intervention of law enforcement;
(5) requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
(6) constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
(7) involves a participant’s location being unknown by provider staff who are assigned protective oversight.

All major incidents must be reported within 48 hours of witnessing or discovering an incident has occurred, using the IME’s Iowa Medicaid Portal Access (IMPA) System. Suspected abuse or neglect may be reported to the statewide abuse reporting hotline operated by DHS.

Child and dependent adult abuse is an inclusive definition that includes physical and sexual abuse, neglect and exploitation. Child abuse is defined in Iowa Code 232.68, and may include any of the following types of acts of willful or negligent acts or omissions:
- Any non-accidental physical injury.
- Any mental injury to a child’s intellectual or psychological capacity.
- Commission of a sexual offense with or to a child.
- Failure on the part of a person responsible for the care of a child to provide adequate food, shelter, clothing or other care necessary for the child’s health and welfare.
- Presence of an illegal drug in a child’s body as a direct act or omission of the person responsible for the care of a child or manufacturing of a dangerous substance in the presence of a child.

Dependent adult abuse is defined in Iowa Code 235B.2, and may include any of the following types of acts of willful or negligent acts or omissions:
- Physical injury or unreasonable confinement, unreasonable punishment, or assault of a dependent adult.
- Commission of a sexual offense or sexual exploitation.
- Exploitation of a dependent adult.
- Deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care or other care necessary to maintain a dependent adult’s life or health.

When a major incident occurs, provider staff must notify the member or the member’s legal guardian within 24 hours of the incident and distribute a completed incident report form as follows:
- Forward a copy to the supervisor with 24 hours of the incident.
- Send a copy of the report to the member’s case manager and the IME within 24 hours of the incident.
- File a copy of the report in a centralized location and make a notation in the member’s file.

Per Chapter 441 Iowa Administrative Code 77.25(1), “minor incidents” are defined as an occurrence involving a participant during service provision that is not a major incident and that:
(1) results in the application of basic first aid;
(2) results in bruising;
(3) results in seizure activity;
(4) results in injury to self, to others, or to property; or
(5) constitutes a prescription medication error.

Providers are not required to report minor incidents to the IME or MCO, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the member's file. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs, or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the member's file.

As part of the quality assurance policies and procedures for HCBS Waivers, all major incidents will be monitored and remediated by the HCBS Incident Reporting Specialist and HCBS specialists. On a quarterly basis, the Quality Assurance (QA) committee will review data collected on incidents and will analyze data to determine trends, problems and issues in service delivery and make recommendations of any policy changes.

MCOs are also required to develop and implement a major incident management system in accordance with DHS requirements, in addition to maintaining policies and procedures that address and respond to incidents, remediate the incidents to the individual level, report incidents to the appropriate entities per required timeframes, and track and analyze incidents.

MCOs must adhere to the State's quality improvement strategy described in each HCBS waiver and waiver-specific methods for discovery and remediation. MCOs must utilize system information to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. All MCO staff and network providers are required to:

- Report major incidents.
- Respond to major incidents.
- Document major incidents.
- Cooperate with any investigation conducted by the HCBS Quality Assurance and Technical Assistance Unit staff, MCO, or outside agency.
- Receive and provide training on major incident policies and procedures.
- Be subject to corrective action as needed to ensure provider compliance with major incident requirements.

Finally, MCOs must identify and track major incidents, and review and analyze major incidents, to identify and address quality of care and/or health and safety issues, including a regular review of the number and types of incidents and findings from investigations. This data should be used to develop strategies to reduce the occurrence of major incidents and improve the quality of care delivered to members.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information concerning protections is provided to applicants and members at the time of application and at the time of service plan development. During enrollment, and when any updates are made, DHS also provides to members a Medicaid Members Handbook, which contains information regarding filing a complaint or grievance. MCO written member enrollment materials also contain information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect.

In addition, information can also be found on DHS and MCO websites. The DHS website contains a “Report Abuse and Fraud” section, which describes how to report dependent adult child abuse. The same information is also available in written format in the 99 local DHS offices, and members may also call the IME Member Services call center with any questions regarding filing a complaint or grievance.

Finally, the case manager, health home coordinator, or community-based case manager is responsible for assessing a member’s risk factors annually during the reevaluation process, as well as during the quality assurance interview process and the annual IPES interview. DHS recognizes the need to provide training to members using on a more formal process. The state has developed training to ensure that case managers, health home coordinators, and community-based case managers provide this information to members at a minimum on a yearly basis.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Reporting of suspected child or adult abuse to DHS Protective Services is mandatory for all IME HCBS staff, case managers, MCO CBCMs, health home care coordinators, and HCBS providers. DHS Protective Services (PS) receives all mandatory reports of child and dependent adult abuse. If an immediate threat of physical safety is believed to exist, PS makes every effort to examine that child or dependent adult within one hour of receipt and take any lawful action necessary. If the child or dependent adult is not in danger, PS makes every effort to examine the child or dependent adult within 24 hours. PS notifies the member's case manager, health home coordinator or community-based case manager when an investigation has been initiated to ensure they are aware of the alleged abuse, and to ensure that additional services can be added or that changes can be made to the member's plan of care if needed. PS provides an evaluation report within twenty days of receipt of the report, which includes necessary actions, and/or an assessment of services needed. The Central Registry of Abuse and County Attorney also receives PS reports. For both child and dependent adult abuse cases, the member and/or the family are notified of the results in writing by DHS as soon as the investigation has concluded. This applies to both individuals enrolled in fee-for-service or managed care.

If the incident is a situation that has caused, or is likely to cause a serious injury, impairment, or abuse to the member, and if PS has completed, or is in the process of conducting, an investigation the HCBS specialist coordinates activities with PS to ensure the safety of the member is addressed. If PS is not investigating, and immediate jeopardy remains, the member's case manager, health home coordinator, or community-based case manager is notified immediately to coordinate services, and the HCBS Specialist initiates a review within two working days of receipt of the report. If it is determined that immediate jeopardy has been removed or not present, review by the HCBS Specialist is initiated within twenty working days of receipt of report. The HCBS Specialist prepares a report of findings within thirty days of the investigation being completed and presents it to the BLTC, the provider, and interested stakeholders (i.e., members, guardians, etc.). These timelines apply to both individuals enrolled in fee-for-service or managed care.

The BLTC meets biweekly to review critical incident reports of child and dependent adult abuse and member deaths that have been reported through the critical incident reporting process. DHS reviews, and if needed, requests information for follow through and resolution of the abuse allegation and member deaths from the case manager, health home coordinator, community-based case manager, or HCBS Specialist. Requests for information are forwarded to the case manager, health home coordinator or community-based case manager to verify any needed changes and confirm that follow-up has occurred with the member (i.e., changes to a plan of care or the safety or risk plan as necessary). If additional information or actions are required of a provider, the HCBS Specialist works directly with the provider to ensure that performance issues identified in the incident report are addressed. The HCBS Specialist uses the provider's Self-Assessment as the foundation of the review to assure that accuracy in the Self-Assessment and to identify any corrective actions that may be required. The HCBS Specialist generates a report of findings within thirty days of the completion of any review requiring corrective actions.

Information requests to the case manager, health home coordinator, community-based case manager, or HCBS Specialist for follow up are tracked by the HCBS Unit on a weekly basis until the situation has been resolved. DHS implemented a web-based critical incident reporting system September 1, 2009, that significantly enhanced the State's ability to track and trend the discovery, remediation, and improvement of the critical incident reporting process. Revisions have been made to the system based on data collection and feedback from users, further enhancing the process. Incidents are reviewed by the HCBS Quality Oversight Unit within one business day of report and forwarded to the case manager, health home coordinator or community-based case manager as needed to coordinate any follow-up and communication with the member, provider, and/or family/legal guardian. Incidents that lead to targeted review will initiate investigation by the HCBS Quality Oversight Unit within one business day. Findings reports are submitted to the Quality Assurance Manager within 15 days of investigation completion. Once the finding report is approved by the Quality Assurance Manager, the findings report is sent to the provider and case manager, health home coordinator, community-based case manager, or HCBS Specialist.

MCOs are responsible for developing and implementing critical incident management systems in accordance with the DHS requirements. Specifically, MCOs must maintain policies and procedures, subject to DHS review and approval, that: (1) address and respond to incidents; (2) report incidents to the appropriate entities per required timeframes; and (3) track and analyze incidents. This information is utilized to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. Training must be provided to all internal staff and network providers regarding the appropriate procedures for reporting, responding to, and documenting critical incidents. Network providers must provide training to direct care staff regarding the appropriate procedures for reporting, responding to, and documenting critical incidents.

Finally, MCOs must identify and track, review and analyze critical incidents to identify and address quality of care and/or health and safety issues. MCOs must also regularly review the number and types of incidents and findings from investigations, in order to identify trends, patterns, and areas for improvement. Based on these findings, the MCO must develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. Consistent with 441 Iowa Administrative Code 77.25 (3), the following process is followed when a major incident occurs or a staff member becomes aware of a major incident:
(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

a. The staff member's supervisor.
b. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to a guardian, if any, is always required.
c. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization or for members not enrolled with a MCO, the department's bureau of long-term care either:

a. By direct data entry into the Iowa Medicaid Provider Access System, or
b. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

a. The name of the member involved.
b. The date and time the incident occurred.
c. A description of the incident.
d. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.
e. The action that the provider staff took to manage the incident.
f. The resolution of or follow-up to the incident.
g. The date the report is made and the handwritten or electronic signature of the person making the report.

If the critical incident involves the report of child or dependent adult abuse, it is mandatory that this type of critical incident is reported to DHS Protective Services.

If the critical incident does not involve child or dependent adult abuse, it will be reviewed by the MCO. The MCO will notify the member and/or the family of the results upon conclusion of the investigation, on or within 30 days.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The IME has oversight for monitoring incidents that affect all waiver members. The IME HCBS Quality Oversight Unit reviews all critical incident reports as soon as they are reported to DHS. All critical incidents are tracked in a critical incident database that tracks the date of the event, the specific waiver the member is enrolled in, the provider (if applicable), and the nature of the event, and follow up provided. For other non-jeopardy incidents, a review is initiated within twenty days. The HCBS Quality Assurance and Technical Assistance Unit meets biweekly to review data tracked in the critical incident database and to decide if policy changes or additional training are needed. Data is compiled and analyzed in attempt to prevent future incidents through identification of system and provider specific training needs, and individual service plan revisions.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DHS policy regarding restraints is as follows and applies to all types of restraints that may be used by waiver providers. The policy described in this section applies regardless of delivery system (i.e., FFS or MCO), and MCOs are contractually obligated to adhere.

Restraints include, but are not limited to, personal, chemical, and mechanical methods used for the purpose of controlling the free movement of an individual's body. Chemical restraints are most commonly used to calm an individual down in moments of escalation. Other examples of restraints include, but are not limited to, holding a person down with one's hands, tying an individual to a bed, using a straight jacket or demobilizing wrap. As a rights limitation, the restraint procedures must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of restraints must be documented in a member's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

- The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
- Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
- Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
- Restraint, restriction, and behavioral intervention programs shall be time-limited (maximum one year) and shall be reviewed at least quarterly.
- Corporal punishment and verbal or physical abuse are prohibited."

These safeguards are the same regardless of what restraints are used. All restraints must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Restraint procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

Physical and chemical restraints may be allowed depending on the provider's agency policy to ensure that there is an accompanying behavioral intervention plan, documentation of each instance, and monitoring of its use. These types of restraints must be considered on an individual basis after the interdisciplinary team reviews them, and entered into the written plan of care with specific time lines. If a member were placed in a closed room the time frame would need to be determined on an individual basis and spelled out in the service plan. The provider would need to document the use of this restraint in the member's service file each time it was utilized by staff. The provider would be required to have a written policy approved by DHS on the supervision and monitoring of members placed in a closed room, for example monitoring on a fifteen minute basis to assure the health and welfare of the member.

Restraint procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:
- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of restraints and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Restraints and behavioral interventions may only be utilized to teach replacement behaviors when non-

aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. Staff must be trained and exhibit proficiency as described below before administering restraints. An employee's ability to implement a procedure must be documented in one of the following ways:
- A program staff person may observe each employee in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (i) the supervisor's ability to implement the procedure has been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Restraints and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter an member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager, integrated health home coordinator, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements:
- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the member's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the individual and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:
- A Restraint and Behavioral Intervention Program that is a part of the written individual service plan developed by the member's case manager, integrated health home coordinator, or community-based case manager, and in the provider plan of care developed for the member.
- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as, and includes, the following components: (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior; (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors; (iii) description of the conditions that precede the behavior in question; (iv) description of what appears to reinforce and maintain the behavior; and (v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Restraints must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All restraints are explained to the member and their legal representative and agreed upon ahead of time.

Unauthorized use of restraints would be detected via:
- interviews with the member, their family and staff and case manager, integrated health home coordinator, or community-based case manager;
- through review of critical incident reports by DHS and member's case manager, integrated health home coordinator, or community-based case manager on a daily basis;
- DHS and case manager, integrated health home coordinator, or community-based case manager review of written documentation authored by provider staff;
- through the annual review activities associated with the provider Self-Assessment process;
-and by reports from any interested party (complaints).

Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the DHS policy for each type of agency identified restraint is observed and member rights are safeguarded. If it is found that a waiver provider is not observing DHS policy or ensuring a member's rights, adverse action is taken by the IME, which may include sanction, termination, required corrective action, etc.

The member's case manager, integrated health home coordinator, or community-based case manager is responsible to monitor individual plans of care including the use of restraints and behavioral interventions.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The first line of responsibility for overseeing the use of restraints and ensuring safeguards are in place is the member's case manager, integrated health home coordinator, or community based case manager. The use of restraints must be assessed as needed and identified in the individual member's service plan. The use of restraints would also require the development and implementation of a behavior plan and the plan would be included in the member's service plan. The case manager, integrated health home coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restraints would be addressed with the provider of service and corrected as needed.

The State also contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restraints. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether restraints are appropriately incorporated into the service plan, such that restraints are only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of restraints. For fee-for-service members these reports are entered into IMPA, triggering milestones in ISIS that alert case managers and integrated health home coordinators, and prompting the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of restraints, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The HCBS Quality Assurance and Technical Assistance Unit is also responsible for conducting IPES interviews with waiver members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, at the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

Finally, the Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of restraints, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

MCO Community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restraints would be addressed with the provider of service and corrected as needed. In addition, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.).

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of

3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

FFS and MCO
A restrictive intervention is an action or procedure that imposes a restriction of movement that limits a member's movement, access to other individuals, locations or activities, or restricts a member's rights. 441-IAC 77.25(4) describes restrictive interventions as restraints, restrictions and behavioral intervention.

The DHS policy regarding restrictive interventions is as follows, and applies to all types of restraints and restrictions methods that may be used by waiver providers. The use of any restrictive intervention as part of the waiver program is treated as rights limitations of the member receiving services. As a rights limitation, the restrictive interventions must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code 83.67(4)).

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures." All members receiving home- and community-based ID Waiver services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
e. Corporal punishment and verbal or physical abuse are prohibited."

These safeguards are the same regardless of what type of restriction interventions are used. All restrictions must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Restriction interventions must be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

The case manager or community-based case manager has the responsibility to assess the need for the restrictive interventions, identify the specific restrictive intervention, explain why the intervention is being used, identify an intervention plan, monitor the use of the restrictive intervention, and assess and reassess need for continued use. The service plan authorizes the services to be delivered to the member and identifies how they are to be provided. Without the authorization, services cannot be provided to a member.

Providers are required to use the service plan as the basis for the development and implementation of the providers' treatment plan. The provider is responsible for developing a plan to meet the needs of the member and to train all staff on the implementation strategies of the treatment plan, such that the restriction interventions are individualized and in accordance with the previously devised plan. Providers and the case manager or community-based case manager are responsible for documenting all behavioral interventions, including restrictive interventions, in the service plan as well as the member's response to the intervention. Providers and case managers or community-based case managers are also required to submit critical incident reports to the IME, via the IMPA, any time a restrictive intervention is utilized.

Providers are required to maintain a system for the review, approval and implementation of ethical, safe, humane and efficient behavioral intervention procedures, that inform the member and his/her legal guardian of the behavioral intervention policy and procedures at the time of entry into a facility and as changes occur. Non-aversive methods of intervention must be designed and utilized as the option of first use, prior to design or implementation of any behavioral intervention containing aversive techniques.

Behavioral intervention procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a nonaversive program. Behavioral intervention procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. Corporal punishment and verbal or physical abuse are prohibited. Restrictions may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at a minimum the following components:
- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of restrictions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Restrictions and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. A person's ability to implement a procedure must be documented in one of the following ways:
- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met:
(i) the supervisor's ability to implement the procedure has been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter a member's behaviors.

Behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter a member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager's or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements:
- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the member's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the member and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the Behavioral Intervention Program must include:
- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as, and includes, the following components:
(i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the

behavior;
(ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;
(iii) description of the conditions that precede the behavior in question;
(iv) description of what appears to reinforce and maintain the behavior; and
(v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Any restriction as part of the Behavioral Intervention Program must be considered on an individual basis after a review by the interdisciplinary team and entered into the written plan of care with specific time lines. All restrictions in the Behavioral Intervention Program are explained to the member and their legal representative and agreed upon ahead of time. Unauthorized use of restrictions would be detected via interviews with the member, their family and staff and case manager or community-based case manager; through review of critical incident reports by DHS and member's case manager or community-based case manager on a daily basis; case manager or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

A restrictive intervention is an action or procedure that imposes a restriction of movement, that limits a participant's movement, access to other individuals, locations or activities, or restricts a participant's rights. 441-IAC 77.25(4) describes restrictive interventions as restraints, restrictions and behavioral intervention. Per the description of restrictive interventions noted in the application (G-2-b-i)above, Iowa will need to review its inclusion of restraint as a restrictive intervention.

The first line of responsibility for overseeing the use of restrictive interventions and ensuring safeguards are in place is the member's case manager, integrated health home care coordinator, or community based case manager. The use of restrictive interventions must be assessed as needed and identified in the individual member's service plan. The use of restrictions would also require the development and implementation of a restrictive intervention plan and the plan would be included in the participant's service plan. The member's case manager, integrated health home care coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restrictive interventions would be addressed with the provider of service and corrected as needed.

The State contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restrictions. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether restrictions are appropriately incorporated into the service plan, such that restrictions are only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers, regardless if serving FFS or MCO members, are required to submit major incident reports. Categories within the incident report include inappropriate use of restrictions.

FFS
For FFS members, proivder reports of restrictive interventions are entered into IMPA, which trigger milestones in ISIS for fee-for-service members. These triggers alert case managers and integrated health home care coordinators, and prompt the IME HCBS Incident Reporting Specialist to conduct a review of the restrictive intervention. If it is found that the restrictive intervention demands further investigation, the issue is passed to the HCBS Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of restrictions, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to the IME Program Integrity Unit for possible sanctions that may apply.

MCO
For MCO members, provider reports are entered into the designated MCO critical incident reporting system. In the MCO system and processes, MCO CBCMs are alerted along with the MCO Critical Incident Reporting Specialist to conduct a review of the restrictive intervention. Processes for targeted review, provider corrective actions and PI referral, if warranted, are followed as discussed in the FFS process.

IPES INTERVIEWS
The HCBS Quality Assurance Unit is also responsible for conducting IPES interviews for FFS members. The MCOs conducts the same IPES interviews for MCO members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the individual interviewed and service enrollment. IPES interviews are conducted either face-to-face or via telephone at the discretion of the waiver member. All waiver members have the right to decline an interview. The results of these interviews are presented to the state on a quarterly basis.

Finally, the HCBS Unit compiles all data related to incidents associated with the inappropriate use of restrictions, as well as data from periodic and targeted provider reviews. Data is analyzed to identify trends

and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

MCO Community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restrictive interventions would be addressed with the provider of service and corrected as needed. In addition, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.).

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DHS policy regarding seclusion is as follows, and applies to all types of seclusions that may be used by waiver providers, regardless of delivery system (i.e., FFS or MCO) Examples of seclusion include but are not limited to locking an member in a room, locking an member out of an area of their residence, or limiting community time. All incidents of seclusion must be documented in the member's service record and reported to the IME as a critical incident. As a rights limitation, the seclusion procedures must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of seclusion must be documented in a member's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures." All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
e. Corporal punishment and verbal or physical abuse are prohibited."

The same standard is used for seclusion as a restrictive intervention. All seclusions must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Seclusion procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

Seclusion may be allowed depending on the provider's agency policy to ensure that there is an accompanying Behavioral Intervention Plan, documentation of each instance, and monitoring of its use. The use of seclusion can be considered on an individual basis after the interdisciplinary team reviews the Behavioral Intervention Plan and the plan is entered into the member's service plan of care. The provider must document the use of seclusion in the member's service file each time it was utilized by staff. The provider would be required to have a written policy approved by the HCBS Quality Oversight Unit on the supervision and monitoring of members placed in a closed room.

Seclusion procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:
- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of seclusions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Seclusions and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. A person's ability to implement a procedure must be documented in one of the following ways:
- A program staff person may observe each person in a role-play situation in order to document his or her

ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (
i) the supervisor's ability to implement the procedure has been documented by a program staff person;
ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and
(iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Seclusion and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter an member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member service plan and the case manager, health home coordinator, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements.
- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the person's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the individual and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:
- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as and includes the following components:
(i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;
(ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;
(iii) description of the conditions that precede the behavior in question;
iv) description of what appears to reinforce and maintain the behavior; and
v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Seclusions must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All seclusions are explained to the member and their legal representative and agreed upon ahead of time.

Unauthorized use of seclusion would be detected via interviews with the member, their family and staff and

case manager, health home coordinator, or community-based case manager; through review of critical incident reports by DHS and member's case manager, health home coordinator, or community-based case manager on a daily basis; DHS and case manager, health home coordinator, or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints). Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the DHS policy for each type of agency identified seclusion is observed and member rights are safeguarded. If it is found that a waiver provider is not observing DHS policy or ensuring a member's rights, adverse action is taken by the IME, which may include sanction, termination, required corrective action, etc.

The member's case manager, health home coordinator, or community-based case manager, is responsible to monitor individual plans of care including the use of seclusion and behavioral interventions.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The first line of responsibility for overseeing the use of seclusion and ensuring safeguards are in place is the member's case manager, health home coordinator, or community based case manager. The use of seclusion must be assessed as needed and identified in the individual member's service plan. The use of seclusion would also require the development and implementation of a behavior plan and the plan would be included in the member's service plan. The case manager, health home coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of seclusion would be addressed with the provider of service and corrected as needed.

The State contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with seclusion. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether seclusion is appropriately incorporated into the service plan, such that seclusion is only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of seclusion. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service members that alert case managers, health home coordinators and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of seclusion, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The HCBS Quality Assurance and Technical Assistance Unit is also responsible for conducting IPES interviews with waiver members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

Finally, the Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of seclusion, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Per 441 Iowa Administrative Code 77.37(15), respite providers must meet the following requirements as a condition of providing respite care under the ID waiver:
(1) training on provision of medication according to agency policy and procedure; and
(2) the staff member shall not provide any direct service without the oversight of supervisory staff until training is completed.

The case manager or community-based case manager and any provider responsible for medication administration must monitor the documentation of medication administration to ensure adherence to the service plan and provider policies and procedure. The provider agency frequently and routinely monitors medication administration as outlined in their policies and procedures and quality improvement plans. Provider agencies are expected to review medication administration on a daily basis to ensure health and welfare of member as well as perform quality assurance on a timeframe identified by the agency. The case manager or community-based case manager also monitor medications at a minimum annually during the annual service plan development or more frequently as needed. MCO community-based case managers monitor the documentation of medication administration to ensure adherence to the service plan and provider policies and procedures.

Monitoring includes review of the service documentation to ensure that medications have been administered at the designated times and by designated individuals. Further monitoring occurs through the report of major incidents whenever a medication error results in physicians' treatment, mental health intervention, law enforcement intervention, death, or elopement. When a major incident has occurred, follow-up, investigation, and remediation occurs as identified in G.l.d. All medication errors resulting in a major incident report or discovered via complaint are fully investigated. If it is determined that a harmful practice has been detected, the provider agency completes a corrective action plan and may face sanctions depending on severity and negligence of the circumstance.

The Iowa Medicaid program has actively managed Medicaid pharmacy benefits through a Preferred Drug List (PDL) since 2005. A governor appointed medical assistance pharmaceutical and therapeutics (P&T) committee was established for the purpose of developing and providing ongoing review of the PDL. The prior authorization department of the IME Medical Services Unit (MSU) utilizes the PDL to review medication management. First line responsibility lies with the prescriber who is contacted by fax or telephone regarding a prescription. Pharmacists review patient profiles for proper diagnosis, dosage strength and length of therapy.

The DHS Member Services Unit has established procedures to monitor Medicaid members' prescribing physicians and pharmacies. Analysis has established risk thresholds for these factors to mitigate possible abuse, harmful drug reactions, and to improve the outcomes of medication regimes for Medicaid members. When it is identified that members exceed the established risk thresholds, the member is placed in lock-in. Lock-in establishes one prescribing physician and one filling pharmacy for each member. The Member Services Unit also conducts statistical analysis of the use of certain drugs and usage patterns. Identification of trends for prescriptions and usage patterns of high risk or addictive medications is presented to DHS on a monthly or quarterly basis.

Second-line monitoring is conducted concerning the use of behavior modifying medications through a variety of mechanisms. First, member education is designed to ensure appropriate utilization (correcting overutilization and underutilization), at a minimum, and to improve adherence. Second, restriction programs, including policies, procedures, and criteria for establishing the need for the lock-in, may also be implemented. Finally, medication therapy management programs are developed to identify and target members who would most benefit, and include coordination between the participant, the pharmacist and the prescriber using various means of communication and education.

The Drug Utilization Review (DUR) Commission is a quality assurance body, which seeks to improve the quality of pharmacy services and ensure rational, cost-effective medication therapy for Medicaid members in Iowa. The commission reviews policy issues and provides suggestions on prospective DUR criteria, prior authorization guidelines, OTC coverage, and plan design issues. The DUR system provides for the evaluation of individual member profiles by a qualified professional group of physicians and pharmacists, with expertise in the clinically appropriate prescribing of covered outpatient drugs, the clinically appropriate dispensing and monitoring of outpatient drugs, drug use review, evaluations and intervention, and medical quality assurance. Members of this group also have the knowledge, ability, and expertise to target and analyze therapeutic appropriateness, inappropriate long-term use of medication, overuse/underuse/abuse/polypharmacy, lack of generic use, drug-drug

interactions, drug-disease contraindications, therapeutic duplications, therapeutic benefit issues, and cost-effective drug strengths and dosage forms. In addition, the IME MSU reviews Medicaid member records to ensure that the member had a diagnosis or rational documented for each medication taken.

The Department of Inspections and Appeals (DIA) is responsible for Medicaid member's medication regimes for waiver members served in a Residential Care Facility for persons with Intellectual Disabilities (RCF/ID). All medical regimes are included in the member's record. Medications administered by the facility are recorded on a medical record by the individual who administers medication. All RCF/IDs are licensed facilities and must meet all Department of Inspections Administrative Rules to obtain an annually renewable license. Medical records are reviewed during licensure renewal. Persons administrating medication must be a licensed nurse or physician or have successfully completed a department approved medication aide course. If the provider stores, handles, prescribes, dispenses, or administers prescription or over the counter medications the provider is required to develop procedures for the storage, handling, prescribing, dispensing, or administration of medication. For controlled substances, providers must maintain DIA procedures. If the provider has a physician on staff or under contract, the physician must review and document the provider's prescribed medication regime at least annually in accordance with current medical practice. Policies and procedures must be developed in written form by the provider for the dispensing, storage, and recording of all prescription and nonprescription medications administered, monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, including antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics. Policies and procedures are reviewed by the HCBS Specialists for compliance with state and federal regulations. If deficiencies are found, the provider is required to submit a corrective action, and follow-up surveys may be conducted based on the severity of the deficiency.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Second line responsibility is utilized when issues are more complex. Occurrences of high dosage use for certain medications or prescribing drugs for an age group where the drug is not FDA indicated are sent to DHS-IME for review. In some cases edits have been placed in the computer system so the prescriber could not prescribe for age groups not indicated.

Lock-In: Trending and analysis has been conducted by the MSU and “lock-in” strategies have been implemented for individuals who have, historically, multiple prescribers and pharmacies. Identification of these individuals allows the Medicaid payment of only one prescribing physician and one pharmacy. This allows for increased monitoring of appropriate medication management and mitigates the risk associated with pharmacological abuses and negative contraindications.

Drug Utilization Review (DUR) Commission: The DUR is a second line monitoring process with oversight by DHS. The DUR system includes a process of provider intervention that promotes quality assurance of care, patient safety, provider education, cost effectiveness and positive provider relations. Letters to providers generated as a result of the professional evaluation process identify concerns about medication regimens and specific patients. At least one Iowa licensed pharmacist is available to reply in writing to questions submitted by providers regarding provider correspondence, to communicate by telephone with providers as necessary and to coordinate face-to-face interventions as determined by the DUR.

The Department of Inspections and Appeals (DIA): This DIA is responsible for oversight of licensed facilities. DIA communicates all findings to DHS and any issues identified during the RCF/ID licensure process, or critical incidents as they arise. The DIA tracks information and provides training as necessary to improve quality. This information is also shared with DHS. Both the DIA and DHS follow-up with identified RCF/IDs to assure that action steps have been made to ensure potential harmful practices do not reoccur.

HCBS Quality Assurance Unit: DHS contracts with the Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with medication management. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines participant files, and conducts targeted reviews based on complaints, to ascertain whether medications are appropriately incorporated into the service plan. If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

With respect to MCO members, community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of medication would be addressed with the provider of service and corrected as needed. In addition, MCOs must maintain documentation of the member’s medication management done by the MCOs clinical staff; monitor the prescribing patterns of network prescribers to improve the quality of care coordination services provided to members through strategies such as: (a) identifying medication utilization that deviates from current clinical practice guidelines; (b) identifying members whose utilization of controlled substances warrants intervention; (c) providing education, support and technical assistance to providers; and (d) monitor the prescribing patterns of psychotropic medication to children, including children in foster care. Finally, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.).

All waiver service providers are required to submit major incident reports. Categories within the incident report include medication errors. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service participants that alert service workers, case managers, and health home coordinators, and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding medication management, the provider is required to complete a corrective

action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of medication, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Respite Service providers must have policies and procedures developed for dispensing, storage, and recording all prescription and nonprescription medication administered. 441 Iowa Administrative Code Chapter 77.37(15)(b)(2)states:

“Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing. All medications shall be stored in their original containers, with the accompanying physician’s or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer’s name. In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.”

Providers are required to have staff trained on medication administration and provide safe oversight of medication administration. The State does not require specific medication administration curriculum to be used. Providers are responsible to assure that staff has the skills needed to administer medications safely. This can be done through providing staff with an outside medication management training program with a certification issued or an internal training provided by qualified medical staff. There are no uniform requirements in the Iowa Administrative Code for the provision of medication administration or for the self-administration of medications by Medicaid members. The HCBS Quality Oversight Unit verifies the training during the provider onsite review.

The Provider Self-Assessment quality improvement process requires providers to have a policy and procedure for the storage and provision of medication. This process requires a more uniform approach for the provider in the requirements for medication management. The Provider Self-Assessment review checklist used by the HCBS Specialist to review providers identifies the following minimum standards that the medication policy will identify:

- The provider’s role in the management and/or administration of medications
- If staff administers medications, the policy will identify the:
  (1) training provided to staff prior to the administration of medications;
  (2) method of documenting the administration of medications;
  (3) storage of medications;
  (4) the assessment process used to determine the Medicaid member’s role in the administration of medications.

The provider Self-Assessment process also requires providers to have discovery, remediation and improvement processes for medication administration. The information and results of these activities is available to DHS upon request. Currently the self-assessment process is not set forth in the Iowa Administrative Code.

Home Health agencies that provide waiver services must follow Medicare regulations for medication administration and dispensing. All medications must be stored in their original containers with the accompanying physician's or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to Medicaid members and the public. Nonprescription medications shall be labeled with the Medicaid member's name. In the case of medications that are administered on an ongoing long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription. All providers of respite must develop policies that assure that personnel that administer medications have the appropriate skills and that there is oversight by medical personnel.

Provider non-medical waiver staff that administers medications must have oversight of a licensed nurse. If the medication requires, the staff is required to complete a medication management course through a community college.

The requirements for non-medical waiver providers must have in order to administer medications to Medicaid members who cannot self-administer is that the provider must have a written policy in place on what the requirements are for their staff to do this and how. If the medications are psychiatric medications the person would have to have successfully completed a medication aide class. Oversight for a staff member who administers medications that require oversight such as in the case of psychiatric medications would need to follow the requirements as spelled out through the Board of Nursing such as having oversight by a registered nurse. The HCBS Specialists through IME would oversee this policy upon regular reviews of the provider.

State oversight responsibility is described in Appendix H for the monitoring methods that include identification of problems in provider performance and support follow-up remediation actions and quality improvement activities.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Providers are required to complete incidents reports for all occurrences meeting the criteria for major and minor incidents and make the incident reports and related documentation available to DHS upon request. Major incidents must be reported to the BLTC via IMPA. Providers must ensure cooperation in providing pertinent information regarding incidents as requested by DHS.

As part of the major incident reporting process described in Appendix G-1, DHS will review and follow-up on all medication errors that lead to a participant hospitalization or death. This can include the wrong dosage, the wrong medication delivered, medication delivered at the wrong time, Medicaid delivery not documented, unauthorized administration of medication, or missed dosage. Providers are required to submit all medication errors, whether major or minor, to the participant's service worker, case manager, health home coordinator, or community-based case manager when they occur. The service worker, case manager, health home coordinator, or community-based case manager monitors the errors and makes changes to the participant's service plan as needed to assure the health and safety of the member.

The Provider Self-Assessment quality improvement process requires providers to have a policy and procedure regarding medication administration and medication management. The Provider Self-Assessment process also requires that providers have discovery, remediation, and improvement processes for medication administration and medication errors. Specifically, providers are required to have ongoing review of medication management and administration to ensure that medications are managed and administered appropriately. Providers are also required to track and trend all medication errors to assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to DHS upon request and will be reviewed as part of the ongoing Self-Assessment process conducted by the HCBS Specialists. This will include random sampling of providers, incident specific review (complaint and IR follow up) and on-site provider review held every five years. DHS is in the process of promulgating rules to establish the Provider Self-Assessment quality improvement process in the Administrative Code.

Other professionals or family members may report medication error incidents at any time as a complaint. Suspected abuse is reported to the reporting hotline operated by the Department of Human Services.

(b) Specify the types of medication errors that providers are required to *record:*

Providers must track and trend all major and minor incident reports. Per Chapter 441 Iowa Administrative Code 77.34(14), “major incidents” are defined as an occurrence involving a participant during service provision that: (1) results in a physical injury to or by the participant that requires a physician’s treatment or admission to a hospital; (2) results in the death of any person; (3) requires emergency mental health treatment for the participant; (4) requires the intervention of law enforcement; (5) requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; (6) constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or (7) involves a participant’s location being unknown by provider staff who are assigned protective oversight. Service providers, provider staff, service workers, case managers, health home coordinators, and community-based case managers are required to submit incident reports as they are witnessed or discovered. All major incidents must be reported within 48 hours of witnessing or discovering an incident has occurred, using the IME’s Iowa Medicaid Portal Access (IMPA) System. Suspected abuse may be reported to the statewide abuse reporting hotline operated by DHS.

Per Chapter 441 Iowa Administrative Code 77.34(14), “minor incidents” are defined as an occurrence involving a participant during service provision that is not a major incident and that: (1) results in the application of basic first aid; (2) results in bruising; (3) results in seizure activity; (4) results in injury to self, to others, or to property; or (5) constitutes a prescription medication error. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider’s system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the participant’s file.

Providers are required to record all medication errors, both major and minor, that occur. Providers are required to track and trend all medication errors and assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to DHS upon request and will be reviewed as part of the ongoing Self-Assessment process conducted by the HCBS Specialists.

(c) Specify the types of medication errors that providers must *report* to the state:

Only major incidents of medication errors that affect the health and safety of the participant, as defined by the major incident criteria, are required to be reported to the State. All medication errors, both major and minor, are required to be reported to the member’s guardian, service worker, case manager, health home coordinator, or community-based case manager.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Iowa Medicaid Enterprise (IME) is responsible for the oversight of waiver providers in the administration of medications to waiver members. Oversight monitoring is completed through IMPA, the provider Self-Assessment process and monitoring of the participant by the member's case manager or community-based case manager. With respect to MCO members, community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of medication would be addressed with the provider of service and corrected as needed. In addition, MCOs must maintain documentation of the member's medication management done by the MCOs clinical staff; monitor the prescribing patterns of network prescribers to improve the quality of care coordination services provided to members through strategies such as:
(a) identifying medication utilization that deviates from current clinical practice guidelines;
(b) identifying members whose utilization of controlled substances warrants intervention;
(c) providing education, support and technical assistance to providers; and
(d) monitor the prescribing patterns of psychotropic medication to children, including children in foster care.

Finally, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.). All of these processes have been described in detail in this Appendix.

All medication errors are considered either major or minor incidents, as noted in Subsection "iii.b" above. Major incidents are reported to the department and follow the incident reporting follow up protocol of the department.

DHS contracts with the HCBS Quality Oversight Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with medication management. The Quality Oversight Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and Federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether medications are appropriately incorporated into the service plan. If the Quality Oversight Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to the Program Integrity Unit for possible sanctions (suspension, probation, termination, etc.).

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate medication administration. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service members that alert case managers and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding medication administration, the provider is required to complete a CAP and implement the CAP to 100% compliance. Again, if it is found that the circumstances are more serious, recommendations are made to the Program Integrity Unit for possible sanctions (suspension, probation, termination, etc.).

The Quality Oversight Unit compiles all data related to incidents reported in IMPA associated with the inappropriate medication administration, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to the IME. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and

welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
HW-a1: The IME will measure the total number and percent of IAC-defined major critical incidents requiring follow-up escalation that were investigated. Numerator = # of critical incidents that received follow-up as required; Denominator = # of critical incidents requiring follow-up escalation

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Data collected in the FFS and MCO CIR databases..

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:
HW-a2: The IME will measure CIs that identify a reportable event of abuse, neglect, exploitation, or unexplained death and were followed upon appropriately. Numerator = # of CIRs that identified a report was made to DHS protective services and/or appropriate follow up was initiated; Denominator = # of CIs that identified a reportable event of abuse, neglect, exploitation, and/or unexplained death

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
FFS and MCO CIR databases

Responsible Party for	**Frequency of data**	**Sampling Approach**

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
HW-b1: The IME will identify all unresolved critical incidents which resulted in a targeted review and were completed to resolution. Numerator = # of targeted reviews resulting from an incident which were resolved within 60 days; Denominator = # of critical incidents that resulted in a targeted review.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
FFS/HCBS Unit and MCO data obtained from CIR databases.

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 policies and procedures for the use or prohibition of restrictive interventions***

(including restraints and seclusion) are followed.

Performance Measures

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

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

Performance Measure:
HW-c1: The IME will measure the total # & % of providers with policies for restrictive measures that are consistent with State and Federal policy and rules, and followed as written. Numerator = # providers reviewed that have policies for restrictive measures that were implemented as written; Denominator = total # of providers reviewed that identified having policies for restrictive measures.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Provider's policies and procedures. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
HW-d1: The IME will measure the number and percent of providers meeting state

and federal requirements relative to individual waivers. Numerator = # of Quality Assurance reviews that did not receive a corrective action plan; Denominator = # of provider Quality Assurance Reviews completed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
All QA reviews that don't result in a corrective action. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The HCBS Quality Assurance unit and each MCO is responsible for monitoring and analyzing data associated with the major incidents reported for members on waivers. For both FFS and MCO members, new CIRs are reviewed on a daily basis and follow-up is initiated immediately; routine monitoring continues through resolution.

Data is pulled from the data warehouse and from MCO reporting on a regular basis for programmatic trends, individual issues and operational concerns. Reported incidents of abuse, medication error, death, rights restrictions, and restraints are investigated further by the HCBS Incident Reporting Specialist as each report is received. The analysis of this data is presented to the state on a quarterly basis.

The HCBS provider oversight unit, and each MCO, is responsible for conducting IPES interviews with waiver members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

he HCBS Incident Reporting Specialist and each MCO analyzes data for individual and systemic issues. Individual issues require communication with the case manager or community based case manager to document all efforts to remediate risk or concern. If these efforts are not successful, staff continues efforts to communicate with the case manager, the case manager's supervisor, and protective services when necessary. All remediation efforts of this type are documented in the monthly and quarterly reports.

The HCBS Specialists conducting interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. MCO are responsible for research and follow up to flagged responses.
General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes to provider policy.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the

waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The IME is the single state agency that retains administrative authority of Iowa's HCBS Waivers. Iowa remains highly committed to continually improve the quality of services for all waiver programs. The IME discovered over the course of submitting previous 1915(c) waiver evidence packages that previously developed performance measures were not adequately capturing the activities of the IME. For this reason, state staff developed new performance measures to better capture the quality processes that are already occurring or being developed. New performance measures were approved by CMS on October 1, 2018.

Based on contract oversight and performance measure implementation, the IME holds weekly policy staff and long term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff.

Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance group gathers on a monthly basis to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. ISIS will only be utilized for fee-for-service members.

All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas. The QM/QI program must have objectives that are measurable, realistic and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 Subpart E and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program. The State has developed a draft-reporting manual for the MCOs to utilize for many of the managed care contract reporting requirements, including HCBS performance measures. The managed care contract also allows for the State to request additional regular and ad hoc reports.

Iowa acknowledges that improvements are necessary to capture data at a more refined level, specifically individual remediation. While each contracting unit utilizes their own electronic tracking system or OnBase (workflow management), further improvements must be made to ensure that there are not preventable gaps collecting individual remediation. The State acknowledges that this is an important component of the system; however the terrain where intent meets the state budget can be difficult to manage.

The IME supports infrastructure development that ensures choice is provided to all Medicaid members seeking services and that these services are allocated at the most appropriate level possible. This will increase efficiency as less time is spent on service/funding allocation and more time is spent on care coordination and improvement. A comprehensive system of information and referrals ensures that all individuals are allowed fully informed choices prior to facility placement.

A comprehensive system of information and referrals shall also be developed such that all individuals are allowed fully informed choices prior to facility placement. Many program integrity and ACA initiatives will assist in system improvements. These include improvements to provider screening at enrollment, tighter sanction rules, and more emphasis on sustaining quality practices.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☒ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: Contracted Entities (Including MCOs)	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The HCBS QIO collects and analyzes quality measures and remediation activities and incorporates those results into ongoing quality improvement activities. The QA committee reviews recommendations and remediation activities to prioritize any identified system or process improvements.

All contracted MCOs are accountable for improving quality outcomes and developing a QMIP that incorporates ongoing review of all major service delivery areas. In accordance with 42 CFR 438.202 , the State maintains a written strategy for assessing and improving the quality of services offered by MCOs including , but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries .

MCOs must comply with the standards established by the State and must provide all information and reporting necessary for the State to carry out its obligations for the State quality strategy. IME performs an annual review of each MCO. This is generally conducted at the time of the annual External Quality Review (EQR) and includes a determination of contract compliance, including that for fraud and abuse reporting and training. EQR is performed as federally required, and committee reports are reviewed during an annual visit. The MCO uses its utilization management practices to develop interest in patterns that might lead to investigative actions. All of this is reported to the State and authenticated as it can be used during onsite visits and through regular reports.

MCO quality management and quality improvement (QM/QI)programs must have objectives that are measurable, realistic, and supported by consensus among the MCOs' medical and quality improvement staff. Through the QMIP, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QMIP program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 subpart D and the standards of the credentialing body by which the MCO is credentialed in development of its QMIP. The State retains final authority to approve the MCOs' QMIP, and the State Medical Services conducts an annual EQR of each MCO to ensure that they are following the outlined QMIP plan.

MCOs must attain and maintain accreditation from the National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC). Each MCO must achieve accreditation at the earliest date allowed by NCQA or URAC. Accreditation must be maintained throughout the life of the MCO's contract at no additional cost to the State.

The HCBS QIO collects and analyzes quality measures and remediation activities and incorporates those results into ongoing quality improvement activities. The HCBS QIO makes recommendations for system or process improvements for the QA committee review.

The QA committee reviews recommendations and remediation activities to prioritize any identified system or process improvements

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The IME reviews the State QIS system no less than annually. Strategies are continually adapted to establish and sustain better performance through improvements in skills, processes, and products. Evaluating progress toward system goals is an ongoing, creative process that has to involves multiple stakeholders in the process. System evaluation includes regular review of the QIS due to the dynamic nature of Medicaid policies and regulations, as well as the changing climate of the member and provider communities. The QA committee meets on a monthly basis to review quality assurance and review all performance measures.
The QA Committee reviews the remediation tracking log monthly to ensure timely and appropriate follow through based on contract oversight and performance measure implementation to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff. Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement.

Data from QMIP activities is also presented to the HCBS QA Committee on a quarterly basis. The QA Committee reviews the data, makes recommendations for changes in policy to the IME Policy staff and Bureau Chief. The QA Committee also uses this information to direct HCBS Provider Quality Oversight Specialists to provide training, technical assistance, or other activity. The QA Committee monitors training and technical assistance activities to assure consistent implementation statewide. The QA Committee also directs workgroups on specific activities of quality improvement and other workgroups are activated as needed.
The QA Committee is made up of QIO and IME Policy staff. Minutes are taken at each of the meetings, which show evidence that analysis of data is completed and recommendations for remediation and system improvement s are made.

IME analyzes general system performance through the management of contract performance benchmarks, ISIS reports, and Medicaid Value Management reports and then works with contractors, providers, and other agencies regarding specific issues. HCBS Annual Reports are sent to the Iowa
Association of Community Care Providers. Reports are also available to agencies, waiver providers, participants, families, and other interested parties upon request.

Finally, IME QA Leadership Committee meets monthly to review all Medicaid performance reports from the prior reporting period. Reviews any action remediation, follow up, and makes recommendations as needed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

The state of Iowa uses the Participant Experience Survey (PES). The PES is an interview tool developed by MEDSTAT under a contract from CMS. Iowa has added a few Iowa specific questions around employment to the PES.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

This section applies to all AIDS/HIV Waiver services, including CDAC and Personal Care services provided through the Consumer Choices Option (CCO) the state's self-direction program. CDAC and Personal Care services are not treated differently from other waiver services.

The IME enters into and establishes a contract with each MCO prior to assigning members to be managed by the MCO. The contract is a comprehensive document that details the requirements of the MCO in managing the Medicaid and waiver services for those members on the BI waiver. The IME sends each MCO a monthly eligibility file called the 834 file. All current information for all members with eligibility in the upcoming month including demographic information is included in this file. The 834 file is used to identify member enrollment with the MCO for authorization of the capitated payment to the MCO. The eligibility file indicates any change in eligibility status, whether from FFS to MCO, MCO to FFS or a change from one MCO to another. The IME also sends each MCO a Long Term Services and Supports File on a daily basis and monthly at months end which includes all current and historical information for members with HCBS Waiver or LTC eligibility in the upcoming month. The LTSS file is used to identify member enrollment in an HCBS Waiver who is assigned to the MCO for authorization of the capitated payment to the MCO.

The IME Program Integrity (PI) unit conducts audits on all Medicaid Provider types including HCBS providers. Any suspected fraud is referred to the Department of Inspection and Appeals Medicaid Fraud and Control Unit (MFCU). The PI Unit vendor is contractually required to review a minimum of 60 cases in each quarter across all provider types. Reviewed cases include providers who are outliers on multiple parameters of cost, utilization, quality of care, and/or other metrics. Reviews are also based on referrals and complaints received. Reviews include review of claims data and service documentation to detect such aberrancies as up-coding, unbundling, and billing for services not rendered. This monitoring may involve desk reviews or provider on-site reviews. During a desk review the provider is required to submit records for review. The PI vendor must initiate appropriate action to recover improper payments on the basis of its reviews. They must work with the Core MMIS contractor to accomplish required actions on providers, including requests to recover payment through the use of credit and adjustment procedures.

The PI vendor must report findings from all reviews to DHS, including monthly and quarterly written reports detailing information on provider review activity, findings and recoveries. Requests for provider records by the PI unit include a documentation checklist, listing the specific records that must be provided for the audit or review pursuant to Iowa Administrative Code to document the basis for services or activities provided. Reviews are conducted in accordance with Iowa Administrative Code.

The vast majority of HCBS claims are paid through MCOs. The IME Program Integrity unit only reviews claims submitted through the Fee-For-Service (FFS) system for members who are not enrolled in an MCO. There are a relatively small number of HCBS claims in the FFS universe, and as such statistical sampling is unnecessary. It is more efficient and productive for the PI Unit to use more targeted strategies to identify providers for review, such as using data analysis and algorithms to identify billing aberrancies, as well as referrals and complaints that come from various sources. The PI vendor may conduct on-site reviews, but there is no requirement for a set percentage of reviews to be conducted on-site.

Should the State require a provider to perform a self-review, the prescribed methodology for review is determined on a case-by-case basis, and is generally determined based on the nature and scope of the issue identified. In previous years, all HCBS claims were paid through the FFS system; currently the vast majority of HCBS claims are paid by MCOs. The state compares the results of the MCO program integrity efforts to the results achieved in past years. However, MCO operations tend to rely more on prior authorization of services and pre-payment claims editing to control costs, and as such this type of comparison will not be straightforward and may not provide useful information.

When the PI vendor identifies an overpayment for FFS claims, a Preliminary Report of Tentative Overpayment (PROTO) letter is sent to the provider. The PROTO letter gives the provider an opportunity to ask for a re-evaluation and they may submit additional documentation at that time. After the re-evaluation is complete, the provider is sent a Findings and Order for Repayment (FOR) letter to notify them of any resulting overpayment. Both the PROTO letter and the FOR letter are reviewed and signed off by state PI staff prior to mailing. The FOR letter also includes appeal rights to inform the provider that they may appeal through the State Fair Hearing process. When overpayments are recovered, claims adjustments are performed which automatically results in the FFP being returned to CMS.

The OHCDS Medicaid audit is subject to the same standards and processes as outlined for FFS. The state's contracted MCOs are also responsible for safeguarding against, and investigating reports of, suspected fraud and abuse. MCOs are required to fully cooperate with the DHS PI Unit by providing data and ongoing communication and collaboration. Per 42 CFR 438.608 and 42 CFR Part 455, MCOs must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The PI Plan must be updated annually and

submitted to DHS for review and approval. The MCOs are also required to make referral to IME and the MFCU for any suspected fraudulent activity by a provider. On a monthly basis, the MCO must submit an activity report to DHS, which outlines the MCO's PI-related activities and findings, progress in meeting goals and objectives, and recoupment totals. Each MCO is also required to meet in person with the IME PI Unit, the IME Managed Care Oversight Bureau, and the MFCU on at least a quarterly basis to coordinate on open cases and review the MCO's program integrity efforts. Iowa's MCOs continuously conduct reviews/audits on providers in their networks. The degree to which these include HCBS providers varies over time depending on tips received and leads from data analytics.

As part of the EQR process, the contractor performs onsite reviews of the MCOs that include processes that impact AIDS/HIV Waiver providers and members. Reviews include credentialing files, critical processes such as service authorization validation, claims processing, training and care coordination.

The State reviews monthly, quarterly, annual reports and compliance plans to provide oversight on the MCO programs. Each MCO has meetings monthly with the State and the Medicaid Fraud Control Unit (MFCU) to review fraud waste and abuse referral information and provide any updates regarding open investigations. Monthly fraud waste and abuse referrals, audits/investigations, closed cases, overpayment letters, overpayments collected, among other numerical values are tracked and trended with the previous year's data on a dashboard updated monthly. There will be on-site audits beginning in SFY20 for MCO oversight to validate correct reporting. These type of audits will be on a regular basis. The State will begin a program integrity review of MCO claims to ensure providers are billing and rendering services appropriately. The State will notify the MCOs of any review findings for them to pursue further program integrity activities with the provider.

MCOs must also coordinate all PI efforts with IME and Iowa's MFCU. MCOs must have in place a method to verify whether services reimbursed were actually furnished to members as billed by providers, and must comply with 42 CFR Part 455 by suspending payments to a provider after DHS determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual/entity unless otherwise directed by DHS or law enforcement. MCOs shall comply with all requirements for provider disenrollment and termination as required by 42 CFR §455.

The Auditor of the State has the responsibility to conduct periodic independent audit of the waiver under the provisions of the Single Audit Act. All HCBS cost reports will be subject to desk review audit and, if necessary, a field audit. However, the Waiver does not require the providers to secure an independent audit of their financial statements.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:
FA-a2: The IME will determine the number of clean claims that are paid by the managed care organizations within the timeframes specified in the contract. Numerator = # of clean claims that are paid by the managed care organization within the timeframes specified in the contract; Denominator = # of Managed Care provider claims.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
Claims Data Adjudicated claims summary, claims aging summary, and claims lag report.

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

Data Aggregation and Analysis:

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

Performance Measure:
FA-a1: The IME will determine the number and percent of FFS reviewed claims supported by provider documentation. Numerator = # of reviewed paid claims where documents supports the units of service; Denominator = # of reviewed paid claims

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
Program Integrity reviews claims and provider documentation for providers already under review.

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *+/- 5% with 95% confidence level*
☒ ***Other***	☐ ***Annually***	☐ ***Stratified***

Specify: *Contracted Entity*		*Describe Group:*
	☐ ***Continuously and Ongoing***	☒ ***Other*** *Specify:* *Annually a sample of claims from the 2 most utilized codes in the first year. Remaining codes are reviewed in following years. Documentation is reviewed to determine appropriate units.*
	☒ ***Other*** *Specify:* *quarterly across all waivers, annually for this waiver*	

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):*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
FA-b1: The IME will measure the number and percent of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for waiver services provided. Numerator = # of reviewed claims paid using IME-approved rate methodologies; Denominator = # of reviewed paid claims.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
The DW Unit query pulls paid claims data for all seven of the HCBS waivers

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

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

Data Aggregation and Analysis:

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

Performance Measure:
FA-b2: The IME will measure the number of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology. Numerator: # of Capitation payments made to the MCOs at the approved rates through the CMS certified MMIS. Denominator: # of capitation payments made through the CMS certified MMIS.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS

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

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

Data Aggregation and Analysis:

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

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

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The Program Integrity unit samples provider claims each quarter for quality. These claims are cross-walked with service documentation to determine the percentage of error associated with coding and documentation. This data is reported on a quarterly basis.

MCO claims data is compared to the contractual obligations for MCO timeliness of clean claim payments. Data is provided to the HCBS staff as well as to the Bureau of Managed Care.

MCO contractual definition of a clean claim: A claim that has no defect or impropriety (including any lack of required substantiating Documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments; require screening of all claims, referral to MFCU, or provider suspension.

The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a quarterly basis.

If during the review of capitation payments the IME determines that a capitation was made in error, that claim is adjusted to create a corrected payment.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

All provider rates are part of Iowa Administrative Code (IAC) Rules and are subject to public comment any time there is change. Rate setting methodologies used by the Department are identified in IAC 441- 79.1(1) Types of reimbursement.

Payments for waiver services for fee-for-service (FFS) enrollees are made by DHS through the MMIS. For FFS members, providers submit claims monthly for services provided by the agency. Providers may submit manual or electronic claims form. Electronic claims must utilize a HIPAA compliant software, PC-ACE Pro 32, and be processed by the IME Provider Services Unit. Manual claims are directed to the Iowa Medicaid Enterprise (IME)/Provider Services Unit. Providers submit a claim form that accurately reflects: (1) the provider's approved NPI provider number; (2) the appropriate waiver procedure code(s) that correspond to the waiver services authorized in the ISIS service plan; and (3) the appropriate waiver service unit(s) and fee that corresponds to the ISIS service plan.

The IME issues provider payments weekly every Monday. The MMIS system edits insure that payments will not be made for services that are not included in an approved ISIS service plan. Any change to ISIS data generates a new authorization milestone for the case manager. The ISIS process culminates in a final ISIS milestone that verifies an approved service plan has been entered into ISIS.

For payments made by the IME: Providers are informed about the process for billing Medicaid directly through annual provider training, IME informational bulletins, and the IME provider manual. When a provider enrolls as a Medicaid provider, the IME Provider Services Unit mails the provider information on billing Medicaid directly. The Provider billing manual is also available on the Iowa DHS website at: http://dhs.iowa.gov/policy-manuals/medicaid-provider.

At the time of service plan development, the case manager shares provider rates with the member and the member can chose a provider based on their rates. They may also get rate information from a service provider or by viewing the rates in the IAC available on the DHS website. When a service is authorized in a member's service plan, the providers of services receives a Notice of Decision (NOD), which indicates the participant's name, provider's name, service to be provided, the dates of service to be provided, units of service authorized, and reimbursement rate for the service.

Respite, adult day care (15 min., 1/2 day and full units), financial management services, and independent support broker are reimbursed by fee schedules. The fee schedule is the actual charge made by the provider not to exceed the upper payment limit. The upper payment limit is established to address the reasonableness of the charge. If the provider rate is under the upper max, it is reasonable.

Fee schedules are determined by the department with advice and consultation from the appropriate professional group at the time the fee schedule is first developed. The fees reflect the amount of time and resources involved in each procedure. The fee scheduled rate is applied to all providers equally, meaning all providers may charge up to the maximum fee schedule rate. Provider may charge less than the maximum fees schedule. Individual service rate adjustments are made periodically to correct any rate inequity. With the AIDS/HIV waiver, this is a legislative appropriation process through provider association and individual providers lobbying efforts. The legislature can direct IME to increase or decreased provider rates through a legislative mandate. There is no set cycle for the Legislature to increase or decrease HCBS provider rates. The IME will change the IAC Rules accordingly. All provider rates are part of IAC and are subject to public comment any time there is a rate rule change. Information is on the website and is distributed to stakeholders when there is a change. Rate determination methods are set forth in IAC and subject to the State's Administrative Procedures Act, which requires a minimum twenty-day public comment period.

If product cost is involved, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:
(1) The actual charge made by the provider of service.
(2) The maximum allowance under the fee schedule for the item of service in question.
Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Variations in this methodology are set forth in subrules IAC 79.1(3) to 79.1(9) and 79.1(15). Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website at: dhs.iowa.gov/ime/providers/csrp/fee-schedule.

CDAC (Skilled and Unskilled) are reimbursed on the basis of the agreement of the member and the provider with an upper payment limit established by the State.

For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare. For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in section 1834(a) of the Social Security Act (42 U.S.C. 1395m), payment for durable medical equipment. Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent. Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.
Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality. Payment for used equipment shall not exceed 80 percent of the purchase allowance. No allowance shall be made for delivery, freight, postage, or other the CDAC and CCO services were set in accordance with 441 IAC 79.1(1):c.
When fee schedules are first established for a service, fee schedules are determined by the department with advice and consultation from the appropriate professional groups. For example, when the prevocational and supported employment rates (fee schedule) were being developed, a provider stakeholder group was established and worked with the Department for over two years in the rate development.
Individual service rate adjustments are made periodically to correct any rate inequity. With the AIDS/HIV waiver, this is a legislative appropriation process through provider association and individual providers lobbying efforts. A change to the rate for any service is done at the direction of the IowaLegislature. When the department reviews reimbursement levels for adequacy; historical experience, current reimbursement levels, experiences in other states, and network adequacy are considered. During the past 10 years the legislature has approved a 1% and 2% across the board rate increases for HCBS waiver service providers. The most recent rate adjustment approved by the legislature occurred July 1, 2016 when all HCBS service rates were increased by 1%. The legislature can direct IME to increase or decreased provider rates through a legislative mandate. If so, then IME changes the IAC accordingly. All provider rates are part of the IAC and are subject to public comment any time there is change. This information is on the website as well as distributed to stakeholders when there is a change. Rate determination methods are set forth in IAC and subject to the State's Administrative Procedures Act, which requires a minimum twenty-day public comment period. A public hearing by the state agency to take comments is not required unless at least twenty-five persons demand a hearing, though Agency's often schedule a public hearing regardless of the number of comments received. The state agency may revise a rule in response to comments received but is not required to do so. At the time of service plan development, the case manager shares with the members the rates of the providers, and the member can chose a provider based on their rates. When a service is authorized in a participant's comprehensive services plan, the providers of services receive a Notice of Decision (NOD), which indicates the participant's name, provider's name, service to be provided, the dates of service to be provided, units of service authorized, and reimbursement rate for the service.
The state is currently reviewing all Medicaid fee schedules and will submit a report to the governor and legislature regarding how the current rates compare to the Medicare fee schedule or other appropriate reimbursement methodologies for specific services. The report will include a plan for phased-in implementation of any changes. MCO capitation rate development methodologies are described in the §1915(b) waiver and associated materials.
The services under the AIDS/HIV waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

For fee-for-service members, providers shall submit claims on a monthly basis for waiver services provided to each member served by the provider agency. Providers may submit manual or electronic claim forms. Electronic claims must utilize a HIPAA compliant software, and shall be processed by the IME Provider Services Unit. Manual claims shall be directed to the Iowa Medicaid Enterprise (IME)/Provider Services Unit.

The FMS is responsible to process and pay invoices for approved goods and services included in the CCO participant's written individual budgets, maintain documentation and monitor that payments are reflected in the consumer's written individual budget. ". All support employees that a CCO participant hires must complete time cards and submit them to the FMS in order to be paid for services. All other goods and services purchased that are listed in the member's CCO budget must be submitted to the FMS with a receipt or invoice in order for payment to be made

Providers shall submit a claim form that accurately reflects the following: (1) the provider's approved NPI provider number; (2) the appropriate waiver procedure code(s) that correspond to the waiver services authorized in the ISIS service plan; and (3) the appropriate waiver service unit(s) and fee that corresponds to the ISIS service plan. The member's name and state Medicaid identification number is required on all claim forms.

The IME issues provider payments weekly on each Monday of the month. The MMIS system edits insure that payment will not be made for services that are not included in an approved ISIS service plan. Any change to ISIS data generates a new authorization milestones for the case manager or health home care coordinator. The ISIS process culminates in a final ISIS milestone that verifies an approved service plan has been entered into ISIS. ISIS data is updated daily into MMIS.

For MCO members, providers bill the managed care entity with whom a member is enrolled in accordance with the terms of the provider's contract with the MCO. Providers may not bill Medicaid directly for services provided to MCO members.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The MMIS system edits to make sure that claim payments are made only when a member is eligible for waiver payments and when the services are included in the service plan. A member is eligible for a Medicaid Waiver payment on the date of service as verified in ISIS. The billing validation method includes the date the service was provided, time of service provision, and name of actual member providing the service. Several entities monitor the validity of claim payments: (1) case manager, or health home coordinator ensures that the services were provided by reviewing paid claims information made available to them for each of their members through ISIS; (2) the Iowa Department of Human Services Bureau of Purchased Services performs financial audits of providers to ensure that the services were provided; (3) the IME Program Integrity Unit performs a variety of reviews by either random sample or outlier algorithms.

The MMIS system includes system edits to ensure that prior to issuing a capitation payment to an MCO the member is eligible for the waiver program and is enrolled with the MCO. MCOs must implement system edits to ensure that claim payments are made only when the member is eligible for waiver payments on the date of service. The MCOs are required to develop and maintain an electronic community-based case management system that captures and tracks service delivery against authorized services and providers. The State monitors MCO compliance and system capability through pre-implementation readiness reviews and ongoing monitoring such as a review of sampled payments to ensure that services were provided and were included in the member's approved plan of care. The MCOs are also responsible for program integrity functions with DHS review and oversight.

When inappropriate billings are discovered (i.e.: overpayments determined) the provider is notified in writing of the overpayment determination. The provider either submits a refund check to the IME or the overpayment is set as a credit balance within the MMIS. Future claim payments are then used to reduce and eliminate the credit balance.

Meanwhile, the overpayments are recorded and reported to the state data warehouse using an end-of-month A/R reporting process. Any overpayments determined during a particular month are reported for that month. Any recoveries of these overpayments are similarly recorded and reported to the state data warehouse using the same end-of-month A/R process and for the month in which the recoveries were made. The dates on which the respective overpayments occurred and the recoveries made are part of this month-end A/R reporting. Bureau of Fiscal Management staff then extracts this reporting from the data warehouse to construct the CMS-64 report, the official accounting report submitted by the Department to CMS (the state's claiming mechanism for FFP). The CMS-64 report shows CMS what Iowa's net expenditures are for the quarter and is used to determine a final claim of federal funds. The federal-dollar share of any overpayments not recovered within 12 months of the payment itself must be returned to CMS and this is accomplished through the CMS-64 report as well.

For the Consumer Choice's Option, the FMS is responsible to 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. The FMS is responsible for monitoring 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 and provide to the department an annual independent audit of the financial management service.

Prevention of member coercion:
The case managers, IHH care coordinators, and MCO CCBCMs are responsible for conducting the interdisciplinary team for each member and ensuring the unencumbered right of the member to choose the provider for each service that will meet the member's needs.

The HCBS Unit completes the Iowa Personal Experience Survey to a random sample of members. A specific survey question relates to the members' ability to choose their providers. Any indication coercion will result in follow up action by the HCBS staff.

The IME HCBS Unit observes a random sample of interdisciplinary team (IDT) meetings conducted by MCO Community Based Managers. This allows the HCBS Unit to note any member coercion in choice of providers. HCBS staff then requests the final service plan to ensure that the final plan does include the services, units and providers chosen by the member. Any changes and omissions require followup by the HCBS staff for resolution by the MCO.

As part of the EQR process, the contractor performs onsite reviews of the MCOs that include processes that impact BI Waiver providers and members. Reviews include credentialing files, critical processes such as service authorization validation, claims processing, training and care coordination.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services for fee-for-service enrollees are made by DHS through the MMIS. For fee-for-service members, providers shall submit claims on a monthly basis for waiver services provided to each member served by the provider agency. Providers may submit manual or electronic claim forms. Electronic claims must utilize a HIPAA compliant software, and shall be processed by the IME Provider Services Unit. Manual claims shall be directed to the Iowa Medicaid Enterprise (IME)/Provider Services Unit. Providers shall submit a claim form that accurately reflects the following: (1) the provider's approved NPI provider number; (2) the appropriate waiver procedure code(s) that correspond to the waiver services authorized in the ISIS service plan; and (3) the appropriate waiver service unit(s) and fee that corresponds to the ISIS service plan.

For CCO enrollees the Financial Management Service (FMS) provider receives Medicaid funds on behalf of the member based on the member's approved monthly budget. The FMS is the employer of record and performs all of the following services:

- *Receive Medicaid funds in an electronic transfer.*
- *Process and pay invoices for approved goods and services included in the individual budget.*
- *Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.*
- *Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).*
- *Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.*
- *Verify for the member an employee's citizenship or alien status.*
- *Assist the member with fiscal and payroll-related responsibilities including, but not limited to:*
  - *Verifying that hourly wages comply with federal and state labor rules.*
  - *Collecting and processing timecards.*
  - *Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.*
  - *Computing and processing other withholdings, as applicable.*
  - *Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.*
  - *Preparing and issuing employee payroll checks.*
  - *Preparing and disbursing IRS Forms W-2 and W-3 annually.*
  - *Processing federal advance earned income tax credit for eligible employees.*
  - *Refunding over-collected FICA, when appropriate.*
  - *Refunding over-collected FUTA, when appropriate.*

- *Assist the member in completing required federal, state, and local tax and insurance forms.*
- *Establish and manage documents and files for the member and the member's employees.*
- *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.*
- *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.*
- *Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.*
- *Establish a customer services complaint reporting system.*
- *Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.*
- *Develop a business continuity plan in the case of emergencies and natural disasters.*
- *Provide to the department an annual independent audit of the financial management service.*
- *Assist in implementing the state's quality management strategy related to the financial management service."*

The IME issues provider payments weekly on each Monday of the month. The MMIS system edits insure that payment will not be made for services that are not included in an approved ISIS service plan. Any change to ISIS data generates a new authorization milestone for the case manager or health home care coordinator. The ISIS process culminates in a final ISIS milestone that verifies an approved service plan has been entered into ISIS. ISIS data is updated daily into MMIS.
For payments made by the IME: Providers are informed about the process for billing Medicaid directly through annual provider training, IME informational bulletins, and the IME provider manual. When a provider has been

enrolled as a Medicaid provider, IME Provider Services mails the provider an enrollment packet that includes how the provider can bill Medicaid directly. The Provider billing manual is also available on the Iowa DHS website at: http://dhs.iowa.gov/policy-manuals/medicaid-provider.

Capitation payments to MCOs are made by the MMIS. The MMIS has recipient eligibility and MCO assignment information. When a recipient is enrolled in an MCO, this is reflected on his/her eligibility file and monthly payment flows from the MMIS to the MCO via an 837 transaction. A monthly payment to the MCO on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

The claim details submitted for payment is reviewed and reconciled by the IME and supporting claim detail is maintained. Payment for these services is recorded in the state's accounting system. The accounting records and claim detail provide the audit trail for these payments.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For payments made by the IME:
Providers are informed about the process for billing Medicaid directly through annual provider training, IME informational bulletins, and the IME provider manual.
When a provider has been enrolled as a Medicaid provider, IME Provider Services mails the provider an enrollment packet that includes how the provider can bill Medicaid directly. The Provider billing manual is also available on the Iowa DHS website at: http://dhs.iowa.gov/policy-manuals/medicaid-provider.
The FMS directly pays the CCO self-directed services and individual directed goods Member employees through the Consumer Choices Option (CCO) program are issued instructions on billing through the FMS as authorized on the member's monthly CCO budget. The FMS bills through the MMIS system the self-directed services and individual directed goods that have been paid by the FMS during the previous month. The FMS bills through the MMIS system in the month following the provision of self-directed services.
IME exercises oversight of the fiscal agent through both the ISIS system and through our Core Unit that manages the MMIS system.
For MCO enrollees, for the self-direction option of the waivers, payments will be made to a financial management service provider. Providers are informed about the process for billing by the MCO. The FMS must meet the provider qualifications established by the state, pass a readiness review approved by the state, and be enrolled as a Medicaid provider with the state. The state will also oversee the operations of the financial management service by providing periodical audits.
When a member is being managed by a MCO, all waiver and Medicaid services that a member can receive are paid through the MCO and that there are no waiver services reimbursed outside of the capitated payments.

IME exercises oversight of the fiscal agent through both the ISIS system and through the IME Core Unit. The IME Core Unit performs a myriad of functions for the Iowa Medicaid Enterprise including, but not limited to, processing and paying claims, handling mail, and reporting. This unit also maintains and updates the automated eligibility reporting system known as ELVS. IME has regularly scheduled meetings with Core that has thresholds of measurements they are required to meet to assure quality.

Additional oversight is provided to the program by the IME Program Integrity (PI) payment review detailed in appendix I-1 of this amendment. The Iowa Administrative Code (IAC) for the FMS requires the FMS to conduct an annual independent audit. The FMS also has an on-site review conducted by the HCBS Quality Oversight Unit (QOU). As part of the Quality Assurance contract with the IME, the HCBS QOU reviews the FMS provider for compliance with State and federal requirements. The FMS is an enrolled Medicaid waiver provider and as such, the Home and Community Based QOU conducts an on-site FMS quality assurance review every three years.

☒ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

N/A

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which

these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- (●) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ( ) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ○ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ◉ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

For fee-for-service enrollees, providers receive and retain 100% of the amount claimed to CMS for waiver services. The payment to capitated MCOs is reduced by a performance withhold amount as outlined in the contracts between DHS and the MCOs. The MCOs are eligible to receive some or all of the withheld funds based on the MCO's performance in the areas outlined in the contract between DHS and the MCOs.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

Enrolled Medicaid providers can choose to subcontract to non-enrolled providers for the provision of Home and Vehicle Modifications. The authorization for the service and the Medicaid payment for the authorized service is made to the enrolled Medicaid provider that would then forward payment to the subcontractor in accordance with their contract.

Any subcontractor who is qualified to enroll with Iowa Medicaid is encouraged to do so. No provider is denied Medicaid enrollment for those services that they are qualified to provide. Waiver providers are not required to contract with an OHCDS in order to furnish services to members.

When the case manager or community-based case manager has assessed the need for any waiver service, the member is offered the full choice of available providers. The member has the right to choose from the available providers; the list of providers is available through the case manager or community-based case manager, and is also available through the IME and MCO websites. In accordance with the Iowa Administrative Code, all subcontractors must meet the same criteria guidelines as enrolled providers and the contracting enrolled provider must confirm that all criteria is met.

The Financial Management Services entities are designated as an OHCDS as long as they meet provider qualifications as specified in C-3. The FMS is the only ID waiver provider designated as an OHCDS.Iowa Medicaid Enterprise (the state Medicaid agency) executes a provider agreement with the OHCDS providers and MCOs contract with an IME enrolled Financial Management Services solution. The Financial Management Services provided by the OHCDS is voluntary and an alternative billing and access is provided to both waiver members and providers. Members have free choice of providers both within the OHCDS and external to these providers. Providers may use the alternative certification and billing process developed by the Iowa Medicaid Enterprise. Members are given this information during their service plan development. Providers are given this information by the OHCDS. The Designated OHCDS reviews and certifies that established provider qualifications have been met for each individual or vendor receiving Medicaid reimbursement. Annually each provider will be recertified as a qualified provider.

Employer/employee agreements and timesheets document the services provided if waiver members elect to hire and manage their own workers. The purchase of goods and services is documented through receipts and/or invoices. For each purchase for fee-for-service members, Medicaid funding from the MMIS to the provider of the service is accurately and appropriately tracked through the use of Iowa's ISIS system. Financial oversight and monitoring of the OHCDS is administered by the Iowa Medicaid Enterprise through an initial readiness review to determine capacity to perform the waiver services and throughout the year using a reporting system, random case file studies and the regular Medicaid audit process. MCOs are contractually required to develop a system to track all OHCDS Financial Management Services, which is subject to DHS review and approval. Further, the MCOs maintain financial oversight and monitoring with ongoing review and authority retained by DHS.

A provider must enroll with Medicaid prior to being eligible to enroll with a managed care organization. They are not required to contract with a MCO as this is a provider/MCO contractual arrangement. However, Medicaid will notify the MCO of all providers eligible to provide services.

Each MCO has different systems that maintains authorized service plans. Many of the services are prior authorized and claims are adjudicated against the authorizations.

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d)

how payments are made to the health plans.

◉ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***not selected***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

- (●) ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*
- ( ) ***Applicable***

  Check each that applies:

  - [ ] ***Appropriation of Local Government Revenues.***

    Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

  - [ ] ***Other Local Government Level Source(s) of Funds.***

    Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

As specified in Iowa Administrative Code, Iowa does not reimburse for room and board costs, except as noted for providers of out of home respite services. The provider manuals contain instructions for providers to follow when providing financial information to determine rates. It states that room and board cannot be included in the cost of providing services. Most respite payments are based upon fee schedules detailed in the Iowa Administrative Code. That fee schedule has no allowance for room and board charges. Respite provided by a home health agency is limited to the established Medicare rate.

The exclusion of room and board from reimbursement is ensured by the Provider Cost Audit Unit. When providers submit cost report documentation and rate setting changes, the Provider Cost Audit Unit accounts for all line items and requests justification for all allocated costs (administrative and other). If it is determined that a provider has attempted to include room and board expenses in cost audits or rate setting documentation, the provider is instructed to make the adjustment and further investigation is conducted to determine if previous reimbursement needs to be recouped by the Iowa Medicaid Enterprise.

All providers of waiver services are subject to a billing audit completed by the Department of Human Services Bureau of Purchased services.

Any payment from an MCO to residential settings is made explicitly for the provision of services as defined by this waiver and excludes room and board. As part of the ongoing monitoring process of MCOs, the State will ensure that payments to residential settings are based solely on service costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	9996.54	13963.00	23959.54	31931.23	11989.59	43920.82	19961.28
2	10193.93	14140.26	24334.19	32569.86	12229.38	44799.24	20465.05
3	10391.69	14423.07	24814.76	33221.25	12473.97	45695.22	20880.46
4	10623.74	14711.53	25335.27	33885.68	12723.45	46609.13	21273.86
5	10825.79	15005.76	25831.55	34563.39	12977.92	47541.31	21709.76

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	35	1	34
Year 2	36	1	35

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Hospital	Level of Care: Nursing Facility
Year 3	37	1	36
Year 4	38	1	37
Year 5	39	1	38

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay (ALOS) is expected to remain the same throughout the five years of the waiver. This is based on CMS 372 reports for the past 5 years, historical trends, and assumptions provided by the State's actuary. Lapse rates were included in the assumption calculations provided by the actuary.

The CMS 372 reports used to develop and report ALOS is July 1, 2012 - June 30, 2017.

Total unduplicated number participants were trended at 2% annually over the five years of the waiver. Unduplicated participants were trended based on CMS 372 reports, historical trends, and assumptions provided by the State's actuary. Lapse rates were included in the assumption calculations provided by the actuary.

The CMS 372 reports used to develop and report unduplicated participants is July 1, 2012 - June 30, 2017.

Limitation on the Number of Participants - The state does not limit the number of participants that it serves for the AIDS waiver at any point in time during a waiver year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D is impacted by the transition from a fee-for-service program to a managed care capitation rate program. In the prior waiver period, Factor D was adjusted due to the transition to managed care. In this submission, the post-managed care number of unduplicated participants were increased by 2% each waiver year. The increase in the number of unduplicated participants reflects the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.

The new participants are not expected to change the characteristics (risk profile) of the population. The underlying capitation rates reflect the risk profile of those qualifying for the HCBS waiver, which are reflected in Factor D and Factor D'.

Under this waiver renewal, Factor D increased at a 2.0% trend annually. The projected increase was based on an estimate of future increases to capitation rates under the managed care program, assumptions provided by the State's actuary, and historical trends based on the five most recent 372 submissions. The dates of the 372 submissions used were for the five years from July 1, 2012 to June 30, 2017.

The WY1 renewal Factor D cost was estimated utilizing the WY5 cost in the prior submission (July 1, 2019 through June 30, 2020) as a baseline for the projection. The prior Appendix J submission illustrates an estimated Factor D cost of $9,867.11 in WY5. The WY5 costs are based on a blend of the Factor D cost included in the IA Health Link capitation rates (for IA Health Link members) and historical FFS costs for the residual members not enrolled in IA Health Link. Most AIDS Waiver members are enrolled in the IA Health Link program.

There are several service categories for the AIDS waiver that have zero users and dollars reported in the waiver renewal. These are service categories that are active and available under the AIDS waiver, but are anticipated to have zero activity during the five years of the waiver renewal.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is impacted by the transition from a fee-for-service program to a managed care capitation rate program. In the prior waiver period, Factor D' was adjusted due to the transition to managed care. In this submission, the post-managed care number of unduplicated participants were increased by 2% each waiver year. The increase in the number of unduplicated participants reflects the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.

The new participants are not expected to change the characteristics (risk profile) of the population. The underlying capitation rates reflect the risk profile of those qualifying for the HCBS waiver, which are reflected in Factor D and Factor D'.

Under this waiver renewal, Factor D' increased at a 2.0% trend annually. The projected increase was based on an estimate of future increases to capitation rates under the managed care program, assumptions provided by the State's actuary, and historical trends based on the five most recent 372 submissions. The dates of the 372 submissions used were for the five years from July 1, 2012 to June 30, 2017.

The WY1 renewal Factor D' cost was estimated utilizing the WY5 cost in the prior submission (July 1, 2019 through June 30, 2020) as a baseline for the projection. The prior Appendix J submission illustrates an estimated Factor D' cost of $27,908.01 in WY5. The WY5 costs are based on a blend of the Factor D' cost included in the IA Health Link capitation rates (for IA Health Link members) and historical FFS costs for the residual members not enrolled in IA Health Link. Most AIDS Waiver members are enrolled in the IA Health Link program.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G - The annual trend factor was 2% annually for Factor G and G'. Consideration was given to historical trends between waiver years for the AIDS waiver and the actuarial assumptions accounting for the transition to manage care from the State's actuary when estimating the trend factor. The five most recent 372 (MMIS) reports dated July 1, 2012 through June 30, 2017 were also considered in the trend factor and corresponding estimates.

The change in the number of lives does not have any influence over the calculation of Factor G and/or Factor G' and were established based on historical data and were carried forward based on an average of the five years from the prior 1915(c) waiver filing.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' - The annual trend factor was 2% annually for Factor G and G'. Consideration was given to historical trends between waiver years for the AIDS waiver and the actuarial assumptions accounting for the transition to manage care from the State's actuary when estimating the trend factor. The five most recent 372 (MMIS) reports dated July 1, 2012 through June 30, 2017 were also considered in the trend factor and corresponding estimates.

The change in the number of lives does not have any influence over the calculation of Factor G and/or Factor G' and were established based on historical data and were carried forward based on an average of the five years from the prior 1915(c) waiver filing.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Care	
Homemaker	
Respite	
Home Health Aide	
Nursing	
Financial Management Services	
Independent Support Broker	
Consumer Directed Attendant Care - Skilled	
Consumer-Directed Attendant Care - Unskilled	
Counseling	
Home Delivered Meals	
Individual Directed Goods and Services	
Self Directed Community Support and Employment	
Self Directed Personal Care	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields.*

All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**0.00**
Adult Day Care - Extended Day	☒	Extended Day	0	0.00	0.01	**0.00**	
Adult Day Care - Full Day	☒	Full Day	0	0.00	0.01	**0.00**	
Adult Day Care - Half Day	☒	Half Day	0	0.00	0.01	**0.00**	
Adult Day Care - 15 Minutes	☒	15 Minutes	0	0.00	0.01	**0.00**	
FFS Adult Day Care - Extended Day	☐	Extended Day	0	0.00	0.01	**0.00**	
FFS Adult Day Care - Full Day	☐	Full Day	0	0.00	0.01	**0.00**	
FFS Adult Day Care - Half Day	☐	Half Day	0	0.00	0.01	**0.00**	
FFS Adult Day Care - 15 Minutes	☐	15 Minutes	0	0.00	0.01	**0.00**	
Homemaker Total:							**4806.24**
Homemaker - 15 Minutes	☒	15 Minutes	1	408.00	5.89	**2403.12**	
FFS Homemaker - 15 Minutes	☐	15 Minutes	1	408.00	5.89	**2403.12**	
Respite Total:							**0.00**
Respite - Camp	☒	15 Minutes	0	0.00	0.01	**0.00**	
Respite - ICF/ID	☒	15 Minutes	0	0.00	0.01	**0.00**	
Respite - Hospital or Nursing Facility/Skilled	☒	15 Minutes	0	0.00	0.01	**0.00**	
Respite - Home Care Agency & Non-Facility, Basic Individual	☒	15 Minutes	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**349878.82**
Total: Services included in capitation:	297880.46
Total: Services not included in capitation:	51998.36
Total Estimated Unduplicated Participants:	**35**
Factor D (Divide total by number of participants):	**9996.54**
Services included in capitation:	8510.87
Services not included in capitation:	1485.67
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Specialized Summer Day Camp	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Group	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - RCF/ID	☒	15 Minutes	0	0.00	0.01	0.00	
Respite Resident Camp-Weeklong	☒	15 Minutes	0	0.00	0.01	0.00	
Group Summer Day Camp - Group Recreational	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Home Care Agency & Non-Facility, Group	☒	15 Minutes	0	0.00	0.01	0.00	
Teen Day Camp - 13 to 21 Years Old	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Specialized	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Child Care Center	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Home Care Agency & Non-Facility, Specialized	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Basic Individual	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Nursing Facility	☒	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Camp	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - ICF/ID	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Hospital or Nursing Facility/Skilled	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Basic Individual	☐	15 Minutes	0	0.00	0.01	0.00	

GRAND TOTAL:	**349878.82**
Total: Services included in capitation:	297880.46
Total: Services not included in capitation:	51998.36
Total Estimated Unduplicated Participants:	**35**
Factor D (Divide total by number of participants):	**9996.54**
Services included in capitation:	8510.87
Services not included in capitation:	1485.67
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS Group Specialized Summer Day Camp	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Group	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - RCF/ID	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite Resident Camp-Weeklong	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Group Summer Day Camp - Group Recreational	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Group	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Teen Day Camp - 13 to 21 Years Old	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Specialized	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Child Care Center	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Specialized	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Basic Individual	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Nursing Facility	☐	15 Minutes	0	0.00	0.01	0.00	
Home Health Aide Total:							0.00
Home Health Aide	☒	Visit	0	0.00	0.01	0.00	
FFS Home Health Aide	☐	Visit	0	0.00	0.01	0.00	
Nursing Total:							0.00
Nursing Care in the Home/LPN; Per Hour	☒	Visit	0	0.00	0.01	0.00	
Nursing Care	☒					0.00	

GRAND TOTAL:	349878.82
Total: Services included in capitation:	297880.46
Total: Services not included in capitation:	51998.36
Total Estimated Unduplicated Participants:	35
Factor D (Divide total by number of participants):	9996.54
Services included in capitation:	8510.87
Services not included in capitation:	1485.67
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
in the Home/RN; Per Hour		Visit	0	0.00	0.01		
FFS Nursing Care in the Home/LPN; Per Hour	☐	Visit	0	0.00	0.01	0.00	
FFS Nursing Care in the Home/RN; Per Hour	☐	Visit	0	0.00	0.01	0.00	
Financial Management Services Total:							0.00
Financial Management Services	☒	Month	0	0.00	0.01	0.00	
FFS Financial Management Services	☐	Month	0	0.00	0.01	0.00	
Independent Support Broker Total:							0.00
Independent Support Broker	☒	Hour	0	0.00	0.01	0.00	
FFS Independent Support Broker	☐	Hour	0	0.00	0.01	0.00	
Consumer Directed Attendant Care - Skilled Total:							224796.41
CDAC-Agency - 15 Minutes	☒	15 Minutes	2	185.33	5.70	2112.76	
CDAC-Individual - 15 Minutes	☒	15 Minutes	20	2902.40	3.32	192719.36	
FFS CDAC-Agency - 15 Minutes	☐	15 Minutes	1	185.33	5.70	1056.38	
FFS CDAC-Individual - 15 Minutes	☐	15 Minutes	3	2902.40	3.32	28907.90	
Consumer-Directed Attendant Care - Unskilled Total:							54482.94
CDAC-Agency - 15 Minutes	☒	15 Minutes	2	1859.00	5.82	21638.76	
CDAC-Individual - 15 Minutes	☒	15 Minutes	17	336.00	3.45	19706.40	

GRAND TOTAL:	349878.82
Total: Services included in capitation:	297880.46
Total: Services not included in capitation:	51998.36
Total Estimated Unduplicated Participants:	35
Factor D (Divide total by number of participants):	9996.54
Services included in capitation:	8510.87
Services not included in capitation:	1485.67
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS CDAC-Agency - 15 Minutes	☐	15 Minutes	1	1859.00	5.82	10819.38	
FFS CDAC-Individual - 15 Minutes	☐	15 Minutes	2	336.00	3.45	2318.40	
Counseling Total:							0.00
Counseling - Individual - 15 Minutes	☒	15 Minutes	0	0.00	0.01	0.00	
Counseling - Group - 15 Minutes	☒	15 Minutes	0	0.00	0.01	0.00	
FFS Counseling - Individual - 15 Minutes	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Counseling - Group - 15 Minutes	☐	15 Minutes	0	0.00	0.01	0.00	
Home Delivered Meals Total:							65793.23
Liquid Supplement	☒	Meal	3	25.00	5.24	393.00	
Morning Meal	☒	Meal	1	30.00	8.30	249.00	
Evening Meal	☒	Meal	19	343.86	8.55	55860.06	
Noon Meal	☒	Meal	12	26.77	8.71	2798.00	
FFS Liquid Supplement	☐	Meal	1	25.00	5.24	131.00	
FFS Morning Meal	☐	Meal	1	30.00	8.30	249.00	
FFS Evening Meal	☐	Meal	2	343.86	8.55	5880.01	
FFS Noon Meal	☐	Meal	1	26.77	8.71	233.17	
Individual Directed Goods and Services Total:							0.00
Individual Directed Goods and Services	☒	Month	0	0.00	0.01	0.00	
FFS Individual Directed Goods and Services	☐	Month	0	0.00	0.01	0.00	

GRAND TOTAL:	349878.82
Total: Services included in capitation:	297880.46
Total: Services not included in capitation:	51998.36
Total Estimated Unduplicated Participants:	35
Factor D (Divide total by number of participants):	9996.54
Services included in capitation:	8510.87
Services not included in capitation:	1485.67
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Self Directed Community Support and Employment Total:							**0.00**
Self Directed Community Support and Employment	☒	Month	0	0.00	0.01	**0.00**	
FFS Self Directed Community Support and Employment	☐	Month	0	0.00	0.01	**0.00**	
Self Directed Personal Care Total:							**0.00**
Self Directed Personal Care	☒	Month	0	0.00	0.01	**0.00**	
FFS Self Directed Personal Care	☐	Month	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**349878.82**
Total: Services included in capitation:	297880.46
Total: Services not included in capitation:	51998.36
Total Estimated Unduplicated Participants:	**35**
Factor D (Divide total by number of participants):	**9996.54**
Services included in capitation:	8510.87
Services not included in capitation:	1485.67
Average Length of Stay on the Waiver:	323

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**0.00**
Adult Day Care - Extended Day	☒	Day	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**366981.47**
Total: Services included in capitation:	313903.14
Total: Services not included in capitation:	53078.34
Total Estimated Unduplicated Participants:	**36**
Factor D (Divide total by number of participants):	**10193.93**
Services included in capitation:	8719.53
Services not included in capitation:	1474.40
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care - Full Day	☒	Day	0	0.00	0.01	0.00	
Adult Day Care - Half Day	☒	Half Day	0	0.00	0.01	0.00	
Adult Day Care - 15 Minutes	☒	15 Minutes	0	0.00	0.01	0.00	
FFS Adult Day Care - Extended Day	☐	Extended Day	0	0.00	0.01	0.00	
FFS Adult Day Care - Full Day	☐	Full Day	0	0.00	0.01	0.00	
FFS Adult Day Care - Half Day	☐	Half Day	0	0.00	0.01	0.00	
FFS Adult Day Care - 15 Minutes	☐	15 Minutes	0	0.00	0.01	0.00	
Homemaker Total:							4904.16
Homemaker - 15 Minutes	☒	15 Minutes	1	408.00	6.01	2452.08	
FFS Homemaker - 15 Minutes	☐	15 Minutes	1	408.00	6.01	2452.08	
Respite Total:							0.00
Respite - Camp	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - ICF/ID	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Hospital or Nursing Facility/Skilled	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Home Care Agency & Non-Facility, Basic Individual	☒	15 Minutes	0	0.00	0.01	0.00	
Group Specialized Summer Day Camp	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Group	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - RCF/ID	☒	15 Minutes	0	0.00	0.01	0.00	
Respite	☒					0.00	

GRAND TOTAL:	366981.47
Total: Services included in capitation:	313903.14
Total: Services not included in capitation:	53078.34
Total Estimated Unduplicated Participants:	36
Factor D (Divide total by number of participants):	10193.93
Services included in capitation:	8719.53
Services not included in capitation:	1474.40
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Resident Camp-Weeklong		15 Minutes	0	0.00	0.01		
Group Summer Day Camp - Group Recreational	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Home Care Agency & Non-Facility, Group	☒	15 Minutes	0	0.00	0.01	0.00	
Teen Day Camp - 13 to 21 Years Old	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Specialized	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Child Care Center	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Home Care Agency & Non-Facility, Specialized	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Basic Individual	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Nursing Facility	☒	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Camp	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - ICF/ID	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Hospital or Nursing Facility/Skilled	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Basic Individual	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Group Specialized Summer Day Camp	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Group	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - RCF/ID	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite	☐					0.00	

GRAND TOTAL:	**366981.47**
Total: Services included in capitation:	313903.14
Total: Services not included in capitation:	53078.34
Total Estimated Unduplicated Participants:	**36**
Factor D (Divide total by number of participants):	**10193.93**
Services included in capitation:	8719.53
Services not included in capitation:	1474.40
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Resident Camp-Weeklong		15 Minutes	0	0.00	0.01		
FFS Group Summer Day Camp - Group Recreational	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Group	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Teen Day Camp - 13 to 21 Years Old	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Specialized	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Child Care Center	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Specialized	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Basic Individual	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Nursing Facility	☐	15 Minutes	0	0.00	0.01	0.00	
Home Health Aide Total:							0.00
Home Health Aide	☒	Vist	0	0.00	0.01	0.00	
FFS Home Health Aide	☐	Visit	0	0.00	0.01	0.00	
Nursing Total:							0.00
Nursing Care in the Home/LPN; Per Hour	☒	Visit	0	0.00	0.01	0.00	
Nursing Care in the Home/RN; Per Hour	☒	Visit	0	0.00	0.01	0.00	
FFS Nursing Care in the Home/LPN; Per Hour	☐	Visit	0	0.00	0.01	0.00	
FFS Nursing Care in the Home/RN; Per	☐	Visit	0	0.00	0.01	0.00	

GRAND TOTAL:	366981.47
Total: Services included in capitation:	313903.14
Total: Services not included in capitation:	53078.34
Total Estimated Unduplicated Participants:	36
Factor D (Divide total by number of participants):	10193.93
Services included in capitation:	8719.53
Services not included in capitation:	1474.40
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Hour							
Financial Management Services Total:							0.00
Financial Management Services	☒	Month	0	0.00	0.01	0.00	
FFS Financial Management Services	☐	Month	0	0.00	0.01	0.00	
Independent Support Broker Total:							0.00
Independent Support Broker	☒	Hour	0	0.00	0.01	0.00	
FFS Independent Support Broker	☐	Hour	0	0.00	0.01	0.00	
Consumer Directed Attendant Care - Skilled Total:							239374.60
CDAC-Agency - 15 Minutes	☒	15 Minutes	2	185.30	5.82	2156.89	
CDAC-Individual - 15 Minutes	☒	15 Minutes	21	2902.40	3.39	206621.86	
FFS CDAC-Agency - 15 Minutes	☐	15 Minutes	1	185.30	5.82	1078.45	
FFS CDAC-Individual - 15 Minutes	☐	15 Minutes	3	2902.40	3.39	29517.41	
Consumer-Directed Attendant Care - Unskilled Total:							55599.06
CDAC-Agency - 15 Minutes	☒	15 Minutes	2	1859.00	5.94	22084.92	
CDAC-Individual - 15 Minutes	☒	15 Minutes	17	336.00	3.52	20106.24	
FFS CDAC-Agency - 15 Minutes	☐	15 Minutes	1	1859.00	5.94	11042.46	
FFS CDAC-Individual - 15 Minutes	☐	15 Minutes	2	336.00	3.52	2365.44	
Counseling Total:							0.00
Counseling - Individual - 15 Minutes	☒	15 Minutes	0	0.00	0.01	0.00	

GRAND TOTAL:	366981.47
Total: Services included in capitation:	313903.14
Total: Services not included in capitation:	53078.34
Total Estimated Unduplicated Participants:	36
Factor D (Divide total by number of participants):	10193.93
Services included in capitation:	8719.53
Services not included in capitation:	1474.40
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Counseling - Group - 15 Minutes	☒	15 Minutes	0	0.00	0.01	0.00	
FFS Counseling - Individual - 15 Minutes	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Counseling - Group - 15 Minutes	☐	15 Minutes	0	0.00	0.01	0.00	
Home Delivered Meals Total:							67103.65
Liquid Supplement	☒	Meal	3	25.00	5.34	400.50	
Morning Meal	☒	Meal	1	30.00	8.47	254.10	
Evening Meal	☒	Meal	19	343.86	8.72	56970.72	
Noon Meal	☒	Meal	12	26.77	8.89	2855.82	
FFS Liquid Supplement	☐	Meal	1	25.00	5.34	133.50	
FFS Morning Meal	☐	Meal	1	30.00	8.47	254.10	
FFS Evening Meal	☐	Meal	2	343.86	8.72	5996.92	
FFS Noon Meal	☐	Meal	1	26.77	8.89	237.99	
Individual Directed Goods and Services Total:							0.00
Individual Directed Goods and Services	☒	Month	0	0.00	0.01	0.00	
FFS Individual Directed Goods and Services	☐	Month	0	0.00	0.01	0.00	
Self Directed Community Support and Employment Total:							0.00
Self Directed Community Support and Employment	☒	Month	0	0.00	0.01	0.00	
FFS Self Directed	☐	Month				0.00	

GRAND TOTAL:	366981.47
Total: Services included in capitation:	313903.14
Total: Services not included in capitation:	53078.34
Total Estimated Unduplicated Participants:	36
Factor D (Divide total by number of participants):	10193.93
Services included in capitation:	8719.53
Services not included in capitation:	1474.40
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Support and Employment			0	0.00	0.01		
Self Directed Personal Care Total:							**0.00**
Self Directed Personal Care	☒	Month	0	0.00	0.01	**0.00**	
FFS Self Directed Personal Care	☐	Month	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**366981.47**
Total: Services included in capitation:	313903.14
Total: Services not included in capitation:	53078.34
Total Estimated Unduplicated Participants:	**36**
Factor D (Divide total by number of participants):	**10193.93**
Services included in capitation:	8719.53
Services not included in capitation:	1474.40
Average Length of Stay on the Waiver:	323

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**0.00**
Adult Day Care - Extended Day	☒	Day	0	0.00	0.01	**0.00**	
Adult Day Care - Full Day	☒	Day	0	0.00	0.01	**0.00**	
Adult Day Care - Half Day	☒	Half Day	0	0.00	0.01	**0.00**	
Adult Day Care - 15 Minutes	☒	15 Minutes	0	0.00	0.01	**0.00**	
FFS Adult Day Care -	☐	Extended Day	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**384492.51**
Total: Services included in capitation:	330333.60
Total: Services not included in capitation:	54158.92
Total Estimated Unduplicated Participants:	**37**
Factor D (Divide total by number of participants):	**10391.69**
Services included in capitation:	8927.94
Services not included in capitation:	1463.75
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Day							
FFS Adult Day Care - Full Day	☐	Full Day	0	0.00	0.01	0.00	
FFS Adult Day Care - Half Day	☐	Half Day	0	0.00	0.01	0.00	
FFS Adult Day Care - 15 Minutes	☐	15 Minutes	0	0.00	0.01	0.00	
Homemaker Total:							5002.08
Homemaker - 15 Minutes	☒	15 Minutes	1	408.00	6.13	2501.04	
FFS Homemaker - 15 Minutes	☐	15 Minutes	1	408.00	6.13	2501.04	
Respite Total:							0.00
Respite - Camp	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - ICF/ID	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Hospital or Nursing Facility/Skilled	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Home Care Agency & Non-Facility, Basic Individual	☒	15 Minutes	0	0.00	0.01	0.00	
Group Specialized Summer Day Camp	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Group	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - RCF/ID	☒	15 Minutes	0	0.00	0.01	0.00	
Respite Resident Camp-Weeklong	☒	15 Minutes	0	0.00	0.01	0.00	
Group Summer Day Camp - Group Recreational	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Home Care Agency & Non-Facility, Group	☒	15 Minutes	0	0.00	0.01	0.00	

GRAND TOTAL:	384492.51
Total: Services included in capitation:	330333.60
Total: Services not included in capitation:	54158.92
Total Estimated Unduplicated Participants:	37
Factor D (Divide total by number of participants):	10391.69
Services included in capitation:	8927.94
Services not included in capitation:	1463.75
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Teen Day Camp - 13 to 21 Years Old	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Specialized	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Child Care Center	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Home Care Agency & Non-Facility, Specialized	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Basic Individual	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Nursing Facility	☒	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Camp	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - ICF/ID	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Hospital or Nursing Facility/Skilled	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Basic Individual	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Group Specialized Summer Day Camp	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Group	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - RCF/ID	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite Resident Camp- Weeklong	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Group Summer Day Camp - Group Recreational	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Group	☐	15 Minutes	0	0.00	0.01	0.00	

GRAND TOTAL:	**384492.51**
Total: Services included in capitation:	330333.60
Total: Services not included in capitation:	54158.92
Total Estimated Unduplicated Participants:	**37**
Factor D (Divide total by number of participants):	**10391.69**
Services included in capitation:	8927.94
Services not included in capitation:	1463.75
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS Teen Day Camp - 13 to 21 Years Old	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Specialized	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Child Care Center	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Specialized	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Basic Individual	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Nursing Facility	☐	15 Minutes	0	0.00	0.01	0.00	
Home Health Aide Total:							0.00
Home Health Aide	☒	Visit	0	0.00	0.01	0.00	
FFS Home Health Aide	☐	Visit	0	0.00	0.01	0.00	
Nursing Total:							0.00
Nursing Care in the Home/LPN; Per Hour	☒	Visit	0	0.00	0.01	0.00	
Nursing Care in the Home/RN; Per Hour	☒	Visit	0	0.00	0.01	0.00	
FFS Nursing Care in the Home/LPN; Per Hour	☐	Visit	0	0.00	0.01	0.00	
FFS Nursing Care in the Home/RN; Per Hour	☐	Visit	0	0.00	0.01	0.00	
Financial Management Services Total:							0.00
Financial Management Services	☒	Month	0	0.00	0.01	0.00	
FFS Financial Management Services	☐	Month	0	0.00	0.01	0.00	
Independent Support Broker							0.00

GRAND TOTAL:	384492.51
Total: Services included in capitation:	330333.60
Total: Services not included in capitation:	54158.92
Total Estimated Unduplicated Participants:	37
Factor D (Divide total by number of participants):	10391.69
Services included in capitation:	8927.94
Services not included in capitation:	1463.75
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Independent Support Broker	☒	Hour	0	0.00	0.01	0.00	
FFS Independent Support Broker	☐	Hour	0	0.00	0.01	0.00	
Consumer Directed Attendant Care - Skilled Total:							254360.18
CDAC-Agency - 15 Minutes	☒	15 Minutes	2	185.33	5.94	2201.72	
CDAC-Individual - 15 Minutes	☒	15 Minutes	22	2902.40	3.46	220930.69	
FFS CDAC-Agency - 15 Minutes	☐	15 Minutes	1	185.33	5.94	1100.86	
FFS CDAC-Individual - 15 Minutes	☐	15 Minutes	3	2902.40	3.46	30126.91	
Consumer-Directed Attendant Care - Unskilled Total:							56715.18
CDAC-Agency - 15 Minutes	☒	15 Minutes	2	1859.00	6.06	22531.08	
CDAC-Individual - 15 Minutes	☒	15 Minutes	17	336.00	3.59	20506.08	
FFS CDAC-Agency - 15 Minutes	☐	15 Minutes	1	1859.00	6.06	11265.54	
FFS CDAC-Individual - 15 Minutes	☐	15 Minutes	2	336.00	3.59	2412.48	
Counseling Total:							0.00
Counseling - Individual - 15 Minutes	☒	15 Minutes	0	0.00	0.01	0.00	
Counseling - Group - 15 Minutes	☒	15 Minutes	0	0.00	0.01	0.00	
FFS Counseling - Individual - 15 Minutes	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Counseling - Group - 15 Minutes	☐	15 Minutes	0	0.00	0.01	0.00	

GRAND TOTAL:	384492.51
Total: Services included in capitation:	330333.60
Total: Services not included in capitation:	54158.92
Total Estimated Unduplicated Participants:	37
Factor D (Divide total by number of participants):	10391.69
Services included in capitation:	8927.94
Services not included in capitation:	1463.75
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals Total:							**68415.07**
Liquid Supplement	☒	Meal	3	25.00	5.45	**408.75**	
Morning Meal	☒	Meal	1	30.00	8.64	**259.20**	
Evening Meal	☒	Meal	19	343.86	8.89	**58081.39**	
Noon Meal	☒	Meal	12	26.77	9.07	**2913.65**	
FFS Liquid Supplement	☐	Meal	1	25.00	5.45	**136.25**	
FFS Morning Meal	☐	Meal	1	30.00	8.64	**259.20**	
FFS Evening Meal	☐	Meal	2	343.86	8.89	**6113.83**	
FFS Noon Meal	☐	Meal	1	26.77	9.07	**242.80**	
Individual Directed Goods and Services Total:							**0.00**
Individual Directed Goods and Services	☒	Month	0	0.00	0.01	**0.00**	
FFS Individual Directed Goods and Services	☐	Month	0	0.00	0.01	**0.00**	
Self Directed Community Support and Employment Total:							**0.00**
Self Directed Community Support and Employment	☒	Month	0	0.00	0.01	**0.00**	
FFS Self Directed Community Support and Employment	☐	Month	0	0.00	0.01	**0.00**	
Self Directed Personal Care Total:							**0.00**
Self Directed Personal Care	☒	Month	0	0.00	0.01	**0.00**	
FFS Self Directed Personal Care	☐	Month	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**384492.51**
Total: Services included in capitation:	330333.60
Total: Services not included in capitation:	54158.92
Total Estimated Unduplicated Participants:	**37**
Factor D (Divide total by number of participants):	**10391.69**
Services included in capitation:	8927.94
Services not included in capitation:	1463.75
Average Length of Stay on the Waiver:	323

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							0.00
Adult Day Care - Extended Day	☒	Day	0	0.00	0.01	0.00	
Adult Day Care - Full Day	☒	Day	0	0.00	0.01	0.00	
Adult Day Care - Half Day	☒	Half Day	0	0.00	0.01	0.00	
Adult Day Care - 15 Minutes	☒	15 Minutes	0	0.00	0.01	0.00	
FFS Adult Day Care - Extended Day	☐	Extended Day	0	0.00	0.01	0.00	
FFS Adult Day Care - Full Day	☐	Full Day	0	0.00	0.01	0.00	
FFS Adult Day Care - Half Day	☐	Half Day	0	0.00	0.01	0.00	
FFS Adult Day Care - 15 Minutes	☐	15 Minutes	0	0.00	0.01	0.00	
Homemaker Total:							5100.00
Homemaker - 15 Minutes	☒	15 Minutes	1	408.00	6.25	2550.00	
FFS Homemaker - 15 Minutes	☐	15 Minutes	1	408.00	6.25	2550.00	
Respite Total:							0.00
Respite - Camp	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - ICF/ID	☒	15 Minutes				0.00	

GRAND TOTAL:	403702.30
Total: Services included in capitation:	348458.22
Total: Services not included in capitation:	55244.08
Total Estimated Unduplicated Participants:	38
Factor D (Divide total by number of participants):	10623.74
Services included in capitation:	9169.95
Services not included in capitation:	1453.79
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			0	0.00	0.01		
Respite - Hospital or Nursing Facility/Skilled	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Home Care Agency & Non-Facility, Basic Individual	☒	15 Minutes	0	0.00	0.01	0.00	
Group Specialized Summer Day Camp	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Group	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - RCF/ID	☒	15 Minutes	0	0.00	0.01	0.00	
Respite Resident Camp-Weeklong	☒	15 Minutes	0	0.00	0.01	0.00	
Group Summer Day Camp - Group Recreational	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Home Care Agency & Non-Facility, Group	☒	15 Minutes	0	0.00	0.01	0.00	
Teen Day Camp - 13 to 21 Years Old	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Specialized	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Child Care Center	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Home Care Agency & Non-Facility, Specialized	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Basic Individual	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Nursing Facility	☒	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Camp	☐	15 Minutes	0	0.00	0.01	0.00	

GRAND TOTAL:	**403702.30**
Total: Services included in capitation:	348458.22
Total: Services not included in capitation:	55244.08
Total Estimated Unduplicated Participants:	**38**
Factor D (Divide total by number of participants):	**10623.74**
Services included in capitation:	9169.95
Services not included in capitation:	1453.79
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS Respite - ICF/ID	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Hospital or Nursing Facility/Skilled	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Basic Individual	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Group Specialized Summer Day Camp	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Group	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - RCF/ID	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite Resident Camp-Weeklong	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Group Summer Day Camp - Group Recreational	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Group	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Teen Day Camp - 13 to 21 Years Old	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Specialized	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Child Care Center	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Specialized	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Basic Individual	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Nursing Facility	☐	15 Minutes	0	0.00	0.01	0.00	
Home Health Aide Total:							**0.00**

GRAND TOTAL:	**403702.30**
Total: Services included in capitation:	348458.22
Total: Services not included in capitation:	55244.08
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Factor D (Divide total by number of participants):	**10623.74**
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Services not included in capitation:	1453.79
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Health Aide	☒	Visit	0	0.00	0.01	0.00	
FFS Home Health Aide	☐	Visit	0	0.00	0.01	0.00	
Nursing Total:							0.00
Nursing Care in the Home/LPN; Per Hour	☒	Visit	0	0.00	0.01	0.00	
Nursing Care in the Home/RN; Per Hour	☒	Visit	0	0.00	0.01	0.00	
FFS Nursing Care in the Home/LPN; Per Hour	☐	Visit	0	0.00	0.01	0.00	
FFS Nursing Care in the Home/RN; Per Hour	☐	Visit	0	0.00	0.01	0.00	
Financial Management Services Total:							0.00
Financial Management Services	☒	Month	0	0.00	0.01	0.00	
FFS Financial Management Services	☐	Month	0	0.00	0.01	0.00	
Independent Support Broker Total:							0.00
Independent Support Broker	☒	Hour	0	0.00	0.01	0.00	
FFS Independent Support Broker	☐	Hour	0	0.00	0.01	0.00	
Consumer Directed Attendant Care - Skilled Total:							269746.01
CDAC-Agency - 15 Minutes	☒	15 Minutes	2	185.33	6.05	2242.49	
CDAC-Individual - 15 Minutes	☒	15 Minutes	23	2902.40	3.53	235645.86	
FFS CDAC-Agency - 15 Minutes	☐	15 Minutes	1	185.33	6.05	1121.25	
FFS CDAC-Individual - 15	☐					30736.42	

GRAND TOTAL:	403702.30
Total: Services included in capitation:	348458.22
Total: Services not included in capitation:	55244.08
Total Estimated Unduplicated Participants:	38
Factor D (Divide total by number of participants):	10623.74
Services included in capitation:	9169.95
Services not included in capitation:	1453.79
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Minutes		15 Minutes	3	2902.40	3.53		
Consumer-Directed Attendant Care - Unskilled Total:							**59061.06**
CDAC-Agency - 15 Minutes	☒	15 Minutes	2	1859.00	6.18	**22977.24**	
CDAC-Individual - 15 Minutes	☒	15 Minutes	18	336.00	3.66	**22135.68**	
FFS CDAC-Agency - 15 Minutes	☐	15 Minutes	1	1859.00	6.18	**11488.62**	
FFS CDAC-Individual - 15 Minutes	☐	15 Minutes	2	336.00	3.66	**2459.52**	
Counseling Total:							**0.00**
Counseling - Individual - 15 Minutes	☒	15 Munites	0	0.00	0.01	**0.00**	
Counseling - Group - 15 Minutes	☒	15 Minutes	0	0.00	0.01	**0.00**	
FFS Counseling - Individual - 15 Minutes	☐	15 Minutes	0	0.00	0.01	**0.00**	
FFS Counseling - Group - 15 Minutes	☐	15 Minutes	0	0.00	0.01	**0.00**	
Home Delivered Meals Total:							**69795.23**
Liquid Supplement	☒	Meal	3	25.00	5.56	**417.00**	
Morning Meal	☒	Meal	1	30.00	8.81	**264.30**	
Evening Meal	☒	Meal	19	343.86	9.07	**59257.39**	
Noon Meal	☒	Meal	12	26.77	9.24	**2968.26**	
FFS Liquid Supplement	☐	Meal	1	25.00	5.56	**139.00**	
FFS Morning Meal	☐	Meal	1	30.00	8.81	**264.30**	
FFS Evening Meal	☐	Meal	2	343.86	9.07	**6237.62**	
FFS Noon Meal	☐	Meal	1	26.77	9.24	**247.35**	

GRAND TOTAL:	**403702.30**
Total: Services included in capitation:	348458.22
Total: Services not included in capitation:	55244.08
Total Estimated Unduplicated Participants:	**38**
Factor D (Divide total by number of participants):	**10623.74**
Services included in capitation:	9169.95
Services not included in capitation:	1453.79
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Directed Goods and Services Total:							**0.00**
Individual Directed Goods and Services	☒	Month	0	0.00	0.01	**0.00**	
FFS Individual Directed Goods and Services	☐	Month	0	0.00	0.01	**0.00**	
Self Directed Community Support and Employment Total:							**0.00**
Self Directed Community Support and Employment	☒	Month	0	0.00	0.01	**0.00**	
FFS Self Directed Community Support and Employment	☐	Month	0	0.00	0.01	**0.00**	
Self Directed Personal Care Total:							**0.00**
Self Directed Personal Care	☒	Month	0	0.00	0.01	**0.00**	
FFS Self Directed Personal Care	☐	Month	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**403702.30**
Total: Services included in capitation:	348458.22
Total: Services not included in capitation:	55244.08
Total Estimated Unduplicated Participants:	**38**
Factor D (Divide total by number of participants):	**10623.74**
Services included in capitation:	9169.95
Services not included in capitation:	1453.79
Average Length of Stay on the Waiver:	323

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**0.00**
Adult Day Care - Extended Day	☒	Day	0	0.00	0.01	**0.00**	
Adult Day Care - Full Day	☒	Day	0	0.00	0.01	**0.00**	
Adult Day Care - Half Day	☒	Half Day	0	0.00	0.01	**0.00**	
Adult Day Care - 15 Minutes	☒	15 Minutes	0	0.00	0.01	**0.00**	
FFS Adult Day Care - Extended Day	☐	Extended Day	0	0.00	0.01	**0.00**	
FFS Adult Day Care - Full Day	☐	Full Day	0	0.00	0.01	**0.00**	
FFS Adult Day Care - Half Day	☐	Half Day	0	0.00	0.01	**0.00**	
FFS Adult Day Care - 15 Minutes	☐	15 Minutes	0	0.00	0.01	**0.00**	
Homemaker Total:							**5206.08**
Homemaker - 15 Minutes	☒	15 Minutes	1	408.00	6.38	**2603.04**	
FFS Homemaker - 15 Minutes	☐	15 Minutes	1	408.00	6.38	**2603.04**	
Respite Total:							**0.00**
Respite - Camp	☒	15 Minutes	0	0.00	0.01	**0.00**	
Respite - ICF/ID	☒	15 Minutes	0	0.00	0.01	**0.00**	
Respite - Hospital or Nursing Facility/Skilled	☒	15 Minutes	0	0.00	0.01	**0.00**	
Respite - Home Care Agency & Non-Facility, Basic Individual	☒	15 Minutes	0	0.00	0.01	**0.00**	
Group Specialized Summer Day Camp	☒	15 Minutes	0	0.00	0.01	**0.00**	
Respite - HHA	☒					**0.00**	

GRAND TOTAL:	**422205.67**
Total: Services included in capitation:	365862.78
Total: Services not included in capitation:	56342.88
Total Estimated Unduplicated Participants:	**39**
Factor D (Divide total by number of participants):	**10825.79**
Services included in capitation:	9381.10
Services not included in capitation:	1444.69
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group		15 Minutes	0	0.00	0.01		
Respite - RCF/ID	☒	15 Minutes	0	0.00	0.01	0.00	
Respite Resident Camp-Weeklong	☒	15 Minutes	0	0.00	0.01	0.00	
Group Summer Day Camp - Group Recreational	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Home Care Agency & Non-Facility, Group	☒	15 Minutes	0	0.00	0.01	0.00	
Teen Day Camp - 13 to 21 Years Old	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Specialized	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Child Care Center	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Home Care Agency & Non-Facility, Specialized	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - HHA Basic Individual	☒	15 Minutes	0	0.00	0.01	0.00	
Respite - Nursing Facility	☒	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Camp	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - ICF/ID	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Hospital or Nursing Facility/Skilled	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Basic Individual	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Group Specialized Summer Day Camp	☐	15 Minutes	0	0.00	0.01	0.00	

GRAND TOTAL:	**422205.67**
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Total: Services not included in capitation:	56342.88
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Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
FFS Respite - HHA Group	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - RCF/ID	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite Resident Camp-Weeklong	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Group Summer Day Camp - Group Recreational	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Group	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Teen Day Camp - 13 to 21 Years Old	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Specialized	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Child Care Center	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Home Care Agency & Non-Facility, Specialized	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - HHA Basic Individual	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Respite - Nursing Facility	☐	15 Minutes	0	0.00	0.01	0.00	
Home Health Aide Total:							0.00
Home Health Aide	☒	Visit	0	0.00	0.01	0.00	
FFS Home Health Aide	☐	Visit	0	0.00	0.01	0.00	
Nursing Total:							0.00
Nursing Care in the Home/LPN; Per Hour	☒	Visit	0	0.00	0.01	0.00	
Nursing Care in the Home/RN; Per Hour	☒	Visit	0	0.00	0.01	0.00	
FFS Nursing	☐					0.00	

GRAND TOTAL:	422205.67
Total: Services included in capitation:	365862.78
Total: Services not included in capitation:	56342.88
Total Estimated Unduplicated Participants:	39
Factor D (Divide total by number of participants):	10825.79
Services included in capitation:	9381.10
Services not included in capitation:	1444.69
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care in the Home/LPN; Per Hour		Visit	0	0.00	0.01		
FFS Nursing Care in the Home/RN; Per Hour	☐	Visit	0	0.00	0.01	0.00	
Financial Management Services Total:							0.00
Financial Management Services	☒	Month	0	0.00	0.01	0.00	
FFS Financial Management Services	☐	Month	0	0.00	0.01	0.00	
Independent Support Broker Total:							0.00
Independent Support Broker	☒	Hour	0	0.00	0.01	0.00	
FFS Independent Support Broker	☐	Hour	0	0.00	0.01	0.00	
Consumer Directed Attendant Care - Skilled Total:							285543.74
CDAC-Agency - 15 Minutes	☒	15 Minutes	2	185.33	6.17	2286.97	
CDAC-Individual - 15 Minutes	☒	15 Minutes	24	2902.40	3.60	250767.36	
FFS CDAC-Agency - 15 Minutes	☐	15 Minutes	1	185.33	6.17	1143.49	
FFS CDAC-Individual - 15 Minutes	☐	15 Minutes	3	2902.40	3.60	31345.92	
Consumer-Directed Attendant Care - Unskilled Total:							60200.70
CDAC-Agency - 15 Minutes	☒	15 Minutes	2	1859.00	6.30	23423.40	
CDAC-Individual - 15 Minutes	☒	15 Minutes	18	336.00	3.73	22559.04	
FFS CDAC-Agency - 15 Minutes	☐	15 Minutes	1	1859.00	6.30	11711.70	
FFS CDAC-Individual - 15	☐					2506.56	

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Services included in capitation:	9381.10
Services not included in capitation:	1444.69
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Minutes		15 Minutes	2	336.00	3.73		
Counseling Total:							0.00
Counseling - Individual - 15 Minutes	☒	15 Minutes	0	0.00	0.01	0.00	
Counseling - Group - 15 Minutes	☒	15 Minutes	0	0.00	0.01	0.00	
FFS Counseling - Individual - 15 Minutes	☐	15 Minutes	0	0.00	0.01	0.00	
FFS Counseling - Group - 15 Minutes	☐	15 Minutes	0	0.00	0.01	0.00	
Home Delivered Meals Total:							71255.15
Liquid Supplement	☒	Meal	3	25.00	5.67	425.25	
Morning Meal	☒	Meal	1	30.00	8.99	269.70	
Evening Meal	☒	Meal	19	343.86	9.26	60498.73	
Noon Meal	☒	Meal	12	26.77	9.43	3029.29	
FFS Liquid Supplement	☐	Meal	1	25.00	5.67	141.75	
FFS Morning Meal	☐	Meal	1	30.00	8.99	269.70	
FFS Evening Meal	☐	Meal	2	343.86	9.26	6368.29	
FFS Noon Meal	☐	Meal	1	26.77	9.43	252.44	
Individual Directed Goods and Services Total:							0.00
Individual Directed Goods and Services	☒	Month	0	0.00	0.01	0.00	
FFS Individual Directed Goods and Services	☐	Month	0	0.00	0.01	0.00	
Self Directed Community Support and Employment							0.00

GRAND TOTAL:	422205.67
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Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Self Directed Community Support and Employment	☒	Month	0	0.00	0.01	0.00	
FFS Self Directed Community Support and Employment	☐	Month	0	0.00	0.01	0.00	
Self Directed Personal Care Total:							0.00
Self Directed Personal Care	☒	Month	0	0.00	0.01	0.00	
FFS Self Directed Personal Care	☐	Month	0	0.00	0.01	0.00	

GRAND TOTAL:	422205.67
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