

HOME AND COMMUNITY BASED SERVICES ILL & HANDICAPPED WAIVER INFORMATION PACKET

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

GENERAL PARAMETERS

- Ill & Handicapped Waiver services are individualized to meet the needs of each member. The following services are available:
 - **Adult Day Care**
 - **Consumer Directed Attendant Care**
 - **Counseling Services**
 - **Home and Vehicle Modification**
 - **Home-Delivered Meals**
 - **Home Health Aide**
 - **Homemaker**
 - **Interim Medical Monitoring and Treatment**
 - **Nursing**
 - **Nutritional Counseling**
 - **Personal Emergency Response System**
 - **Respite**
 - **Consumer Choices Option**
- The services that are considered necessary and appropriate for the member will be determined through an interdisciplinary team consisting of the member, DHS service worker, service provider(s), Iowa Child Health Specialty Clinics regional nurse, and other persons the member chooses.
- All members will have a service plan developed by a DHS service worker in cooperation with the member. A DHS service worker prior to implementation of services must sign and date the service plan.
- The service plan for members **aged 20 or under** must be developed or reviewed taking into consideration those services that may be provided through the individual education plan (IEP) and EPSDT (Care For Kids) plan(s).
- Members shall access all other services for which they are eligible and which are appropriate to meet their needs as a precondition of eligibility for the Ill and Handicapped Waiver.
- All members will have a service plan developed by a DHS service worker in cooperation with the member. A DHS service worker prior to implementation of services must sign and date the service plan.
- The member must choose HCBS services as an alternative to institutional services.
- In order to receive I&H Waiver services, an approved I&H Waiver service provider must be available to provide those services.
- Ill and Handicapped Waiver services cannot be provided when a person is an inpatient of a medical institution.
- Members must need and use at least one unit of service from the I &H waiver during each quarter of the calendar year.
- The total costs of Ill & Handicapped Waiver services cannot exceed the following:

Nursing Level of Care	\$904.00 per month
Skilled Level of Care	\$2631.00 per month
ICF/MR Level of Care	\$3203.00 per month

- A designated number of members (payment slots) are designated to be served under the HCBS IH program.
- The Ill & Handicapped Waiver has an advisory committee that meets regularly to make recommendations and takes action to ensure the waiver best meets the need of the persons it serves.
- Following is the hierarchy for accessing waiver services:
 - Private insurance
 - Medicaid and/or EPSDT (Care For Kids)
 - I&H Waiver services
 - In-Home Health Related Care
- In addition to services available through the IH Waiver assistance may be available through the In-Home Health Related Care program and or the Rent Subsidy Program through the Iowa Finance Authority. Members may contact the Iowa Finance Authority at 1-800-432-7230. .
- IH Waiver members upon reaching the age of 65 may then receive waiver services through the Elderly Waiver upon application.

MEMBER ELIGIBILITY CRITERIA

Members may be eligible for the HCBS Ill & Handicapped waiver services by meeting the following criteria:

- Be an Iowa resident and a United States citizen or a person of foreign birth with legal entry into the United States
- Be determined blind or disabled by the Disability Determination Services or in some exceptions receive Social Security disability benefits
- May be eligible for other Medicaid coverage groups but choose to receive waiver services.
- SSI Requirements
 - All applicants (age 21 and over **and** applicants under age 21) must meet the following SSI requirements:
 - Meet all non-financial requirements for SSI
 - Applicant income cannot exceed 300% of SSI
 - Applicant resources **for age 18 and over** cannot exceed \$2000.00
 - **IN ADDITION TO THE ABOVE LISTED REQUIREMENTS:**
 - **Applicants age 25 and over:**
Must be ineligible for SSI for either or both of the following circumstances:
 - Excess income
 - Deeming of a spouse's income or resources

Members age 21 and over who are currently receiving services from the IH Waiver and are SSI eligible may remain on the waiver through age 24. If they were receiving EPSDT, private duty nursing or intermittent services, these services may continue until they reach age 25, but will be paid for under the waiver. They will be allowed to go above the level of care cost.
 - **Applicants under age 21**
 - Can be eligible for SSI
 - Can be ineligible for SSI for either or both of the following circumstances:
 - Excess income
 - Deeming of a spouse or parent's income or resources

Be determined by the Iowa Medicaid Enterprise, Medical Services to need Nursing Facility, Skilled Nursing Facility or Intermediate Care Facility for the Mentally Retarded level of care

SERVICE DESCRIPTIONS

- **PLEASE NOTE:**

I&H Waiver services are individualized to meet the needs of each member. However, decisions regarding what services are appropriate, the number of units or the dollar amounts of the appropriate services is based on the member's needs as determined by the member and an interdisciplinary team.

ADULT DAY CARE

- WHAT:** Adult day care is an organized program of supportive care in a group environment. The care is provided to members who need a degree of supervision and assistance on a regular or intermittent basis in a day care center.
- WHERE:** Adult day program in the community
- UNITS:** A unit is:
Half day - 1 to 4 hours
Or
Full day - 4 to 8 hours
Or
Extended day - 8 to 12 hours

CONSUMER DIRECTED ATTENDANT CARE (CDAC)

- WHAT:** Assistance to the member with self-care tasks, which the member would typically do independently if the member was otherwise able. The service may be provided by an individual or agency, depending on the member's needs. The member, parent, or guardian shall be responsible for selecting the individual or agency that will provide the components of the CDAC services to be provided.
- The CDAC service may include assistance with non-skilled and skilled services. The skilled services must be done under the supervision of a professional registered nurse or licensed therapist working under the direction of a physician. The registered nurse or therapist shall retain accountability for actions that are delegated.
- Skilled services may include: Tube feedings, intravenous therapy, Parenteral injections, catheterizations, respiratory care, care of decubiti & other ulcerated areas, rehabilitation services, colostomy care, care of medical conditions out of control, post surgical nursing care, monitoring medications, preparing and monitoring response to therapeutic diets, and recording and reporting of changes in vital signs.
- Non-skilled services may include: Dressing, hygiene, grooming, bathing supports, wheelchair transfer, ambulation and mobility, toileting assistance, meal preparation, cooking, eating and feeding, housekeeping, medications ordinarily self-administered, minor wound care, employment support, cognitive assistance, fostering communication, and transportation.
- A determination must be made regarding what services will benefit and assist the member. Those services will be recorded in The HCBS Consumer Directed Attendant Care Agreement Form 470-3372. This Agreement becomes part of the service plan developed for the member.
- This service is only appropriate if the member, parent, guardian, or attorney in fact under a durable power of attorney for health care has the ability to and is willing to manage all aspects of the service.

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

DOES NOT INCLUDE: Daycare, baby-sitting, respite, room and board, parenting, supervision or case management

CDAC cannot replace a less expensive service.

A CDAC provider may not be the spouse of the member or a parent or stepparent of a member aged 17 or under.

An individual CDAC provider cannot be the recipient of respite services provided on behalf of a member receiving HCBS I&H waiver services.

The cost of nurse supervision, if needed

UNITS: A unit is:
 One hour
Or
 One 8 to 24 hour day

MAXIMUM UNITS: The social worker, working with the member and the interdisciplinary team, establishes an amount of dollars that may be used for CDAC. The amount is then entered into the service plan along with information about other HCBS services the member may receive. This monetary information is also entered into The HCBS Consumer Directed Attendant Care Agreement Form 470-3372 along with the responsibilities of the member and the provider and the activities for which the provider will be reimbursed. The member and the provider come to agreement on an hourly or daily billing unit and the cost per unit. A completed copy of the Agreement is distributed to the member, the provider and the DHS service worker. The Agreement becomes part of the service plan. These steps must be completed **prior to** service provision.

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

- The DHS service worker should be aware of and have knowledge of the specific services included in the assisted living facility contract to ensure the following:
 - That assisted living facility services are not duplicative of CDAC services
 - Knowledge of how member needs are being addressed
 - Awareness of member unmet needs that must be included in the care plan
- CDAC payment does not include costs of room and board
- Each member must be determined by IFMC to meet ICF/MR, nursing facility or skilled nursing facility level of care
- The CDAC fee is calculated based on the needs of the member and may differ from individual to individual.

PROVIDER ENROLL: The provider must be enrolled with the Department's fiscal agent and certified as a CDAC provider **prior to** the completion of the member HCBS Consumer Directed Attendant Care Agreement.

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

BILLING: The member as well as the provider must sign the Claim for Targeted Medical Care before it is submitted for payment. This verifies that the services were provided as shown on the billing form.

COUNSELING SERVICES

WHAT: Counseling services are face-to-face mental health services that facilitate home management of the member and prevent institutionalization. Counseling services may be provided to the member's caregiver only when included in the service plan for the member. 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 disability or illness, including terminal illness.

WHERE: The community mental health center or other location used by a provider that meets accreditation under the Mental Health and Disabilities Commission.

UNITS:

A unit is:

A 15-minute increment for individual counseling for the member or the member and the caregiver

Or

1 hour for group counseling

Payment for group counseling is based on the group rate divided by six or, if the number of persons who comprise the group exceeds six, the actual number of persons which comprises the group.

HOME AND VEHICLE MODIFICATION (HVM)**WHAT:**

Physical modifications to the home and/or vehicle to assist with the health, safety and welfare needs of the member and to increase or maintain independence. Competitive bids are essential to determine the cost effectiveness of the projector item. All modification requests are reviewed individually and a determination is made regarding the appropriateness of the modification request.

WHERE:

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

1. Kitchen counters, sink space, cabinets, and special adaptations to refrigerators, stoves, and ovens.
2. Bathtubs and toilets to accommodate transfer, special handles and hoses for showerheads, water faucet controls, and accessible showers and sink areas.
3. Grab bars and handrails.
4. Turnaround space adaptations
5. Ramps, lifts, and door, hall and window widening.
6. Fire safety alarm equipment specific for disability.
7. Voice activated, sound activated, light activated, motion activated and electronic devices directly related to the member's disability.
8. Vehicle lifts, driver specific adaptations, remote start systems, including such modifications already installed in a vehicle.
9. Keyless entry systems
10. Automatic opening device for home or vehicle door.
11. Special door and window locks
12. Specialized doorknobs and handles.
13. Plexiglas replacement for glass windows.
14. Modifications of existing stairs to widen, lower, raise or enclose open stairs.
15. Motion detectors.
16. Low pile carpeting or slip resistant flooring.
17. Telecommunications device for people who are deaf.
18. Exterior hard surface pathway.
19. New door opening.
20. Pocket doors.
21. Installation or relocation of controls, outlets, switches.
22. Air conditioning and air filtering if medically necessary.
23. Heightening of existing garage door opening to accommodate modified van.
24. Bath chairs.

DOES NOT INCLUDE:

Modifications which increase the square footage of the home, items for replacement which are the responsibility of the homeowner/landlord, vehicle purchase, fences, furnaces or any modifications or adaptations available through regular Medicaid.

Purchasing, leasing or repairs of a motorized vehicle are excluded.

UNIT:

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

MAXIMUM:

The member is eligible for up to \$6060 per year.

If the amount of the modification is allocated monthly, the monthly amount must be included in the monthly dollar cap according to the dollar amount established for the level of care for up to \$505 per month. Three bids for each item or project before approval can be determined.

HOME DELIVERED MEALS

WHAT: Home-delivered meals are prepared outside of the member's home and delivered to the member.

Each meal must ensure that the member receives a minimum of one-third of the daily-recommended dietary allowance as established by the Food and Nutrition Research Council of the National Academy of Sciences. Each meal may also be a liquid supplement, which meets the minimum one-third standard.

When a restaurant provides home delivered meals, a nutritional consultation must be completed. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and explain what constitutes the minimum one-third daily dietary allowance.

WHERE: Delivered to the member's home

UNIT: A unit is one meal.

MAXIMUM UNITS: Fourteen (14) meals may be delivered during any week.

HOME HEALTH AIDE (HHA)

WHAT: Unskilled medical services which provide direct personal care. This service may include assistance with oral medications, eating, bathing, dressing, personal hygiene, accompaniment to medical services, transport to and from school or medical appointments, and other necessary activities of daily living that is intended to prevent or postpone institutionalization.

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

Transportation as a home health aide waiver service may be accessed *after* all transportation services available under the Medicaid medical transportation program have been utilized.

WHERE: In the member's home except when transporting to or from school or medical appointments. Not the provider's home.

DOES NOT INCLUDE: Homemaker services such as cooking and cleaning or services that meet intermittent guidelines or those provided under the EPSDT authority.

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

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

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

Services not covered by EPSDT include:

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

UNIT: A unit is a visit.

HOMEMAKER SERVICES

- WHAT:** 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. Homemaker service is limited to the following components: essential shopping; limited house cleaning and meal preparation.
- WHERE:** In the member's home and community. Not the provider's home.
- DOES NOT INCLUDE:** Services shall not be simultaneously reimbursed with other waiver services.
- UNIT:** A unit is one hour.
This service must be billed in whole units.

INTERIM MEDICAL MONITORING AND TREATMENT (IMMT)

- WHAT:** Monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting for persons age 20 and under. Interim medical monitoring and treatment services shall provide experiences for each member's social, emotional, intellectual, and physical development. The service will include development care and any special services for a member with special needs; and will include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.
- The service allows the member's usual caregivers to be employed. Interim medical monitoring and treatment may also be used after the death of a usual caregiver. Interim medical monitoring and treatment services may include supervision for the child during transportation to and from school when not available through school or other sources. Interim medical monitoring and treatment services may also be provided for a limited period of time when the usual caregiver is involved in the following circumstances:
- Attendance at academic or vocational training
 - Employment search
 - Hospitalization
 - Treatment for physical or mental illness
- Note: The child must first be maximizing services under intermittent, EPSDT, home health or private duty nursing to be eligible to access this service.
- WHERE:** In the member's home, a registered group child care home, a registered family child care home, a licensed child care center, or during transportation to and from school. Providers of this service must be at least 18 years of age, not be the spouse of the member or parent or stepparent of a member age 17 or under, not be the usual caregiver, be qualified by training or experience as determined by the usual caregiver, and a licensed medical professional on the member's interdisciplinary team to provide medical intervention or intervention in a medical emergency
- DOES NOT INCLUDE:** May not duplicate any regular Medicaid or waiver services provided under the state plan
- Daycare services to children who do not have a medical monitoring or treatment need.
- Medicaid intermittent coverage: Regular Medicaid provides for intermittent coverage of skilled nursing and home health aide services provided in the person's home for both children and adults. Services are usually provided two to three hours per day for two to three days per week. Intermittent skilled nursing coverage includes visits up to five days per week and daily or multiple daily visits for wound care or insulin injections. Intermittent home health aide coverage includes visits twice per day up to seven days per week for persons attending school or working or when ordered by the physician and included in the plan of care, not to exceed 28 hours per week.
- EPSDT (Care For Kids) program: EPSDT services for persons under age 21 only include private duty nursing and personal care services which meet the definition of medical necessity as provided by CMS for EPSDT. Services may be provided to a child outside of the child's residence when normal life activities take the child outside the residence.
- Services not covered by EPSDT include:
- Services to children with Medicaid HMO coverage
 - Mental health services to children enrolled in the Iowa Plan

- Well child care
- Respite
- Transportation
- Homework assistance
- Services to other household members

UNIT: A unit is one hour.

MAXIMUM: Twelve (12) one-hour units of service per day

NURSING SERVICES

WHAT: Nursing care services are provided by a licensed nurse. The services are ordered by and included in the plan of treatment established by the physician. The services shall be based on the medical necessity of the member and the Iowa Board of Nursing scope of practice guidelines.

WHERE: In the member's home. Not the provider's home.

DOES NOT INCLUDE: Nursing services provided outside of the home or services which meet the intermittent guidelines or those provided under the EPSDT authority

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

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

Services not covered by EPSDT include:

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

This nursing service shall not be simultaneously reimbursed with other Medicaid services.

UNIT: A unit is a visit.

NUTRITIONAL COUNSELING

WHAT: Nutritional counseling for a severe nutritional problem or condition, which is beyond standard medical management

WHERE: In the member's home. Not the provider's home.

UNIT: A unit is a 15-minute increment.

PERSONAL EMERGENCY RESPONSE SYSTEM

WHAT: An electronic device connected to a 24-hour staffed system which allows the member to access assistance in the 9-15-09 rev. 12-9-10 rev.

event of an emergency

WHERE: The emergency response system is connected to the member's home phone or a portable emergency button carried by the member.

UNITS: A unit is:
One time installation fee
And/or
One month of service

MAXIMUM UNITS: 12 months of service per State fiscal year (July 1-June 30)

RESPITE

WHAT: Respite care services are services provided to the member that gives temporary relief to the usual caregiver and provides all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the member to remain in the member's current living situation.

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

WHERE: Respite may be provided in the member's home, another family's home, camps, organized community programs (YMCA, recreation centers, senior citizens centers, etc.), ICF/MR, RCF/MR, hospital, nursing facility, skilled nursing facility, assisted living program, adult day care center, foster group care, foster family home or DHS licensed daycare.

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

DOES NOT INCLUDE Services shall not be reimbursable if the living unit is otherwise reserved for persons on a temporary leave of absence.

Respite **cannot** to be provided to members residing in the family, guardian or usual caregiver's home during the hours in which the usual caregiver is employed unless it is in a camp setting.

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

UNITS: A unit is one hour. Services are limited by the monthly maximum available for all waiver services.

MAXIMUM UNITS: Fourteen consecutive days of 24-hour respite care may be reimbursed
and
Respite services provided to three or more individuals for a period exceeding 24 consecutive hours for individuals who require nursing care because of a mental or physical condition must be provided by a licensed health care facility as described in the Iowa Code chapter 135C.

CONSUMER CHOICES OPTION

WHAT: The **Consumer Choices Option** is an option that is available under the Ill and Handicapped waiver. This option will give you more control over a targeted amount of Medicaid dollars. You will use these dollars to develop an individual budget plan to meet your needs by directly hiring employees and/or purchasing other goods and services.

The **Consumer Choices Option** offers more choice, control and flexibility over your services as well as more responsibility. Additional assistance is available if you choose this option. You will choose an Independent Support Broker who will help you develop your individual budget and help you recruit employees. You will also work with a Financial Management Service that will manage your budget for you and pay your workers on your behalf. Contact your service worker for more information. Additional information may also be found at the website: www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html

Services that may be included in the individual budget under the Consumer Choices Option are:

- Consumer Directed Attendant Care (unskilled)
- Home and Vehicle modification
- Home-delivered meals
- Homemaker service.
- Basic individual respite care

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

UNITS: A monthly budget amount is set for each member

APPLICATION PROCESS

The application process for the IH Waiver requires a coordinated effort between the local Department of Human Services and non-Department agencies on behalf of the prospective member. If you are currently working with your local Department of Human Services personnel, please contact that person regarding the application process.

Please respond immediately to correspondence from an income maintenance worker or a DHS service worker. This will decrease the amount of time needed to complete the application process and assist in communication.

1. Application for Medicaid (Title XIX) and the Ill & Handicapped Waiver is made with an income maintenance worker (IM) at the local DHS office.
For adults applying for the Ill & Handicapped Waiver, an appointment will be scheduled with the IM worker. For children applying for this waiver, telephone contact will be made to the family home. Documentation necessary to complete this contact may include:
 - Financial records
 - Title XIX card
 - Letter of Medicaid eligibility
 - Verification of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) or State Supplemental Assistance (SSA) eligibility or ineligibility. If assistance is not currently being received, the member should contact the local Social Security office for verification of ineligibility. A disability determination denial can be appealed.
2. The DHS service worker will complete an assessment tool, Home and Community Based Services Assessment or Reassessment Form 470-0659 for members age 22 and older. Child Health Specialty Clinics staff will complete this assessment for members up to age 22.
3. The Iowa Medicaid Enterprise, Medical Services will review the Home and Community Based Services Assessment or Reassessment Form 470-0659 to determine if member needs require a nursing facility, skilled nursing facility or intermediate care facility mentally retarded level of care.
 - If the member does not meet the level of care, the IM worker will send a Notice of Decision (NOD) notifying the member of the denial. The member has the right to appeal the decision. The process for appealing is explained on the NOD.
4. An interdisciplinary team meeting is conducted to determine the services that are needed, the amount of service to be provided and the provider(s) of the services. The interdisciplinary team meeting will be attended by the member/family, DHS service worker, I&H Waiver service provider(s), and may also include legal representatives, a regional nurse from the Iowa Child Health Specialty Clinics, school personnel, therapists or other professional or support persons. The result of the interdisciplinary team decisions will be a service plan developed by the DHS service worker.
5. The DHS service worker will issue a Notice of Decision if the member is approved to receive Ill & Handicapped Waiver services.