HOME AND COMMUNITY BASED SERVICES
ELDERLY WAIVER
INFORMATION PACKET

The Medicaid Home and Community Based Services Elderly Waiver (HCBS Elderly) provides service funding and individualized supports to maintain eligible consumers 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

- Elderly Waiver services are individualized to meet the needs of each consumer. The following services are available:
  - **Adult Day Care**
  - **Assistive Devices**
  - **Case Management**
  - **Chore Services**
  - **Consumer Directed Attendant Care**
  - **Emergency Response**
  - **Home and Vehicle Modifications**
  - **Home Delivered Meals**
  - **Home Health Aide**
  - **Homemaker Services**
  - **Mental Health Outreach**
  - **Nursing Care**
  - **Nutritional Counseling**
  - **Respite**
  - **Senior Companions**
  - **Transportation**

- The services which are considered necessary and appropriate for the consumer will be determined through an interdisciplinary team consisting of the consumer, Case Management Project For Frail Elderly case manager, DHS service worker, service provider(s) and other persons the consumer chooses.

- All consumers will have a service plan developed by a Case Management Project For Frail Elderly case manager in cooperation with the consumer. A DHS service worker prior to implementation of services must sign the service plan. The consumer must receive case management services from the Long Term Care Coordination Unit Designated Case Management Project for the Frail Elderly.

- Consumers 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 Elderly Waiver.

- A service plan must be developed and reviewed annually with the interdisciplinary team and signed by the DHS service worker.

- The consumer must choose HCBS services as an alternative to institutional services.

- In order to receive Elderly Waiver services; an approved Elderly Waiver service provider must be available to provide those services.

- Medicaid waiver service cannot be simultaneously reimbursed with another Medicaid waiver service or a Medicaid service.

- Elderly waiver services cannot be provided when a person is an inpatient of a medical institution.

- Consumers must need and use one billable Elderly Waiver service during each calendar quarter.

- The total costs of Elderly Waiver services cannot exceed the following:
    - Nursing Level of Care $1084.00 per month
    - Skilled Level of Care $2554.00 per month

- Following is the hierarchy for accessing waiver services:
  Private insurance
  Medicaid
  Elderly Waiver services

- Assistance may be available through the In-Home Health Related Care program and the Rent Subsidy Program in addition to services available through the Elderly Waiver.

CONSUMER ELIGIBILITY CRITERIA

Consumers may be eligible for HCBS Elderly 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 65 years of age or older

- Be determined eligible for Medicaid (Title XIX) *as if* the consumer was in a medical institution Consumers may be Medicaid eligible prior to accessing waiver services or be determined eligible through the application process for the waiver program. Additional opportunities to access Medicaid may be available through the waiver program even if the consumer has previously been determined ineligible.

- Be determined by the Iowa Medicaid Enterprise, Medical Services to need Nursing **or** Skilled level of care

SERVICE DESCRIPTIONS

- ***PLEASE NOTE:***
  Elderly Waiver services are individualized to meet the needs of each consumer. However, decisions regarding what services are appropriate, the number of units or the dollar amounts of the appropriate services are based on the consumer's needs as determined by the consumer and an interdisciplinary team.

ADULT DAY CARE

WHAT: 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 a regular or intermittent basis in a day care center.

WHERE: Adult day care program in the community certified to provide Elderly Waiver services

UNITS: A unit is:
Half day - 1 to 4 hours
or
Full day - 4 to 8 hours
or
Extended day - 8 to 12 hours

ASSISTIVE DEVICES

WHAT: Assistive devices are practical equipment products to assist consumers with activities of daily living and instrumental activities of daily living which allow the consumer more independence. These assistive devices may include but are not limited to: long reach brush; extra long shoehorn; non-slip grippers to pick up and reach items; dressing aids; shampoo rinse tray; inflatable shampoo tray; double handled cup and sipper lid.

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

UNIT: A unit is the cost of one item.

MAXIMUM UNIT: The cost of any one assistive device cannot exceed $108.96.

CASE MANAGEMENT SERVICES

WHAT: The goal of case management is to enhance the consumer's ability to exercise choices, make decisions, and take risks that are typical of life, and fully participate in the community.

Case management activities include the following:
- A comprehensive diagnosis and evaluation
- Assistance in obtaining appropriate services and living arrangements
- Coordination of service delivery
- Ongoing monitoring of the appropriateness of services and living arrangements
- Crisis assistance to facilitate referral to the appropriate providers

WHERE: In the consumer's home and community. Not in the provider's home.

UNIT: A unit is a monthly reimbursement.

CHORE SERVICES

WHAT: Chore services are limited to the following activities:

- Window and door maintenance which may include any of the following:
  Changing screen windows and doors, replacing window panes, or washing windows
- Minor repairs to walls, floors, stairs, railings and handles
- Heavy cleaning which may include any of the following:
  Cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, or trash removal
- Yard work which may include any of the following:
  Mowing lawns, raking leaves or shoveling walks

WHERE: In and on the outside of the home and on the consumer's property

UNIT: A unit is a one half-hour (30 minute) increment.

CONSUMER DIRECTED ATTENDANT CARE (CDAC)

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

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

Skilled services may include but are not limited to: Tube feedings, intravenous therapy, parenteral injections, catherizations, respiratory care, care of decubiti & other ulcerated areas, rehabilitation services, colostomy care, care of medical conditions out of control, postsurgical nursing care, monitoring medications, preparing and monitoring response to therapeutic diets, and recording and reporting of changes in vital signs.

Non-skilled services may include but are not limited to: 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 consumer. 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 consumer.

This service is only appropriate if the consumer, 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 consumer's home or community. Not the provider's home.

DOES NOT INCLUDE: Daycare, respite, room and board, or case management

CDAC cannot replace a less expensive service.

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

The cost of nurse supervision, if needed

UNITS: A unit is:

One hour when provided by an individual or agency ***other than an assisted living facility***
or
One 8 to 24 hour day when provided by an individual or agency ***other than an assisted living facility***
or
One month when provided by an assisted living facility. The rate must be prorated per day for partial month of services.

MAXIMUM UNITS: The CM working with the consumer 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 consumer 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 consumer and the provider and the activities for which the provider will be reimbursed. The consumer 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 consumer, the provider and the 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 service worker or case manager should be aware of and have knowledge of the specific services included in the assisted living facility contract to ensure the following:
  - That assisted living facility services are not duplicative of CDAC services
  - Knowledge of how consumer needs are being addressed
  - Awareness of consumer unmet needs that must be included in the service plan
- CDAC payment does not include costs of room and board
- Each consumer must be determined by Iowa Medicaid Enterprise to meet nursing level of care.
- The CDAC fee is calculated based on the needs of the consumer 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 HCBS Directed Attendant Care Agreement.

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

BILLING: The consumer 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.

EMERGENCY RESPONSE SYSTEM

WHAT: An electronic device connected to a 24-hour staffed system which allows the consumer to access assistance in the event of an emergency

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

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)

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 consumer and to increase or maintain independence. All modification requests are reviewed individually and a determination is made regarding the appropriateness of the modification request.

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

1. Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
2. Bathtubs and toilets to accommodate transfer, special handles and hoses for 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 consumer's disability.
8. Vehicle lifts, driver specific adaptations, remote start systems, including such modifications already installed in a vehicle.
9. Keyless entry systems
10. Automatic opening device for home or vehicle door.
11. Special door and window locks
12. Specialized doorknobs and handles.
13. Plexiglas replacement for glass windows.
14. Modification of existing stairs to widen, lower, raise or enclose open stairs.
15. Motion detectors.
16. Low pile carpeting or slip resistant flooring.
17. Telecommunications device for 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.

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

MAXIMUM: The maximum lifetime benefit is $1000.00. This is not included in the monthly total.

HOME DELIVERED MEALS

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

Each meal must ensure that the consumer 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 consumer'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 observation and reporting of physical or emotional needs, assisting with bathing, shampoo, oral hygiene, toileting, ambulation, helping individuals in and out of bed, reestablishing activities of daily living, assisting with oral medications ordinarily self administered and ordered by a physician, performing incidental household services which are essential to the individual's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

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

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

DOES NOT INCLUDE: Homemaker services such as cooking and cleaning or services, which meet the intermittent guidelines.

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.

UNIT: A unit is a visit.

HOMEMAKER

WHAT: Homemaker services are those services provided when the consumer lives alone or when the person who usually performs these functions for the consumer needs assistance. Homemaker service is limited to the following components: Essential shopping; limited house cleaning, accompaniment to medical or psychiatric services; meal preparation, and bathing and dressing for self-directing consumers.

WHERE: In the consumer's home and community. Not the provider's home.

UNIT: A unit is one hour.
Homemaker services must be billed in whole units. Partial hours are not available.

MENTAL HEALTH OUTREACH

WHAT: Services provided in a consumer's home to identify, evaluate and provide treatment and psychosocial support.

The services can be provided only on the basis of a referral from the Case Management Project for the Frail Elderly (CMPFE) interdisciplinary team.

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

UNIT: A unit is a 15-minute increment.

MAXIMUM UNITS: 1440 units (360 hours) per year

NURSING CARE

WHAT: Nursing care services are services provided by a licensed nurse. The services are ordered by and included in the

plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medication; intravenous, hypodermocysis and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the consumer's condition and needs.

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

DOES NOT INCLUDE: Nursing services provided outside of the home or services which meet the intermittent guidelines.

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.

UNIT: A unit is a visit.

MAXIMUM UNITS:	Intermediate level of care -	8 nursing visits per month
	Skilled level of care	No maximum number of visits per month

NUTRITIONAL COUNSELING

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

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

UNIT: A unit is a 15-minute increment.

RESPITE

WHAT: Respite care services are services provided to the consumer 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 consumer to remain in the consumer's current living situation.

- **Specialized respite** means respite provided on a staff to consumer 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 consumer ratio of less than one to one.
- **Basic individual respite** means respite provided on a staff to consumer 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 consumer'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 consumer'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 consumers 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.

SENIOR COMPANIONS

WHAT: A companion who provides non-medical care supervision, oversight and respite. Senior companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks.

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

DOES NOT INCLUDE: Hands on nursing or medical care

UNIT: A unit is one hour.

TRANSPORTATION

WHAT: Transportation services may be provided for consumers to conduct business errands, to complete essential shopping, to receive medical services not reimbursed through medical transportation and to reduce social isolation.

WHERE: In the community as identified in the service plan

UNITS: The units are as follows:

State per mile rate for individual providers

or

Rate established by an Area Agency on Aging for all others

The amount approved in the service plan determines the limit. The limit amount is determined by the consumer's needs.

APPLICATION PROCESS

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

Please respond immediately to correspondence from an income maintenance worker, DHS service worker or case manager for the Frail Elderly. 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 Elderly Waiver is made with an Income Maintenance worker (IM) at the local DHS office.
    - An appointment will be scheduled with the IM. The documentation requested to bring to this appointment may include:
        - Financial records
        - Title XIX card
        - Letter of Medicaid eligibility
        - Verification of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) or State Supplemental Assistance (SSA) eligibility, if applicable. If assistance is not currently being received, a request may be made to apply at the local Social Security office.

2. Two assessment tools, the Functional Abilities Screening Evaluation (FASE) and the I-OASIS will be completed by the local Area Agency on Aging or a DHS service worker.

3. The Iowa Medicaid Enterprise, Medical Services will review the I-OASIS to determine if consumer needs require intermediate or skilled level of care.
    - If the consumer does not meet level of care, the IM will send a Notice of Decision notifying the consumer of the denial. The consumer has the right to appeal the decision. The appeal process is explained on the Notice of Decision.

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 consumer, the Case Management for the Frail Elderly coordinator, the DHS service worker, Elderly Waiver service provider(s) and other support persons the consumer may choose to attend. The end result of the interdisciplinary team decisions will be a joint service plan developed by the Case Management for the Frail Elderly coordinator and the DHS service worker.

5. The DHS service worker's dated signature on the service plan indicates the consumer's approval for Elderly Waiver services.