STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Employees' Manual
Title 18, Chapter C(6)

Revised February 17, 2023

In-Home Health-Related Care Services

Page

Overview

In-home health-related care is a State Supplementary Assistance program to:

- Provide health care in the home
- Prevent out-of-home placement
- Preserve independent self-care

The purpose of the in-home health-related care (IHHRC) supplement is to provide personal services to persons in their own homes when physical or mental problems prevent them from independent self-care. The intent is to prevent or reduce time in institutional care by helping a person stay at home as long as possible.

The services are approved by a physician. Any "skilled services" will be performed under the supervision of a physician, nurse practitioner, clinical nurse specialist, or physician's assistant.

The state supplements the person's income to allow the person to pay for the needed services. The state does not purchase the services directly. The cost of the services must be below a specified limit but above what the person is determined able to pay.

IHHRC shall be provided only when other existing programs cannot meet the client's need. (441 IAC 177.7(1)(a)(2)). Please see Assessing Service Needs.

A client's right to self-determination is paramount. You cannot mandate that a client apply or accept waiver or any other service.

Legal Basis

Iowa Code Chapter 217 governs the establishment, purposes, and general duties of the Department of Health and Human Services.

Iowa Code Chapter 249 provides that State Supplementary Assistance payments may be made to an eligible person receiving "nursing care in the person's own home, certified by a physician as being required, so long as the cost of the nursing care does not exceed standards established by the Department."

Iowa Administrative Code 441, Chapter 177, "In-Home Health-Related Care," establishes the rules for the program. Chapters 50, 51, and 52 establish the rules for application, eligibility, and payment for State Supplementary Assistance.

Administration

The in-home health-related care (IHHRC) supplement is jointly administered by an income maintenance worker and a designated service worker.

Both the service worker and IM worker have roles in determining eligibility for IHHRC services. Both the service worker and IM worker are required to share information with each other.

IHHRC is not considered a long-term care program or a (231C) assisted living program. An individual living in an assisted living facility can apply and receive IHHRC, however, the assisted living program/facility cannot apply on behalf of the individual they are serving.

Chapter Organization

This chapter provides direction regarding the in-home health-related care (IHHRC) program in relation to:

- Determining eligibility
- Planning services
- Requesting certification
- Processing payments
- Monitoring and changing services
- Termination of services

List of Requirements

Legal reference: 441 IAC 177 and 441 IAC 50

Application and Assessment

Medical Eligibility	▪ Person must be under a physician's care. ▪ Skilled Services must be certified by a physician and must be supervised by a supervising practitioner (physician, nurse practitioner, clinical nurse specialist, or physician's assistant). Personal Care Services (non-skilled services) do not need to be supervised by a practitioner.
Financial Eligibility (Determined by income maintenance (IM) worker)	▪ Person must require health care or personal care. ▪ Person's income must be under the current Supplemental Security Income (SSI) standard plus the current maximum IHHRC payment. ▪ HHS service worker or designee helps the client complete form 470-5170 or 470-5170(S), *Application for Health Coverage and Help Paying Costs*, if the client requests assistance. The Income Maintenance (IM) worker may provide this form to the client or the client can print it from the HHS web page.

- Send the completed application to HHS, Imaging Center 4 at:

  Imaging Center 4
  PO Box 2027
  Cedar Rapids, IA 52406
  Email: imagingcenter4@dhs.state.ia.us
  Fax: 515-564-4017

- Upon receipt the IM will then pend the case in IoWANS.

  NOTE: The signed application form in the IM case file serves as the application for both medical and service components of the program. A copy of the application is not required to be kept in the HHS service case file.

  NOTE: At each step in the approval process the HHS service worker will have IoWANS milestones to answer.

- If the person's income is below the SSI benefit amount, refer the person to apply for SSI. (The person is eligible for IHHRC when IM is notified of the person's SSI eligibility.)

Needs Assessment

- Complete form 470-5602, *Service Worker Comprehensive Assessment*, to assess the medical and daily needs of the client.

Opening A Case

- Have the client sign form 470-3951 or 470-3951(S), *Authorization to Obtain or Release Health Care Information*, for the physician and supervising practitioner (if necessary).
- Provide the *Physician's Report/Health Care Plan*, form 470-0673, to the client.

- **If skilled services are needed**, send signed form 470-3951 or 470-3951(S), *Authorization to Obtain or Release Health Care Information*, and completed form 470-0673, *Physician's Report/Health Care Plan*, to the supervising practitioner for review and signature.
- Have the provider sign form 470-3951 or 470-3951(S), *Authorization to Obtain or Release Health Care Information*, for the provider's health care provider.
- Give a copy of signed form 470-3951 or 470-3951(S), *Authorization to Obtain or Release Health Care Information*, to the provider along with form 470-0672, *Provider Health Assessment*, which must be completed by the provider's physician, advanced registered nurse practitioner, or a physician assistant working under the direction of a physician to certify the provider's ability to provide assistance.

Approval

- **If skilled services are needed**, ensure both the physician and supervising practitioner have reviewed and signed form 470-0673, Physician's Reporter/Plan of Care.
- Receive completed form 470-0672, *Provider Health Assessment* from the provider.
- The provider must have a valid Medicaid provider number. Before entering provider demographic information, search IoWANS to determine if the provider has a Medicaid provider number. If the provider does not have a traditional provider number, IoWANS will generate a non-traditional provider number upon entry of all required fields.
- Complete form 470-0636, *Provider Agreement* with the client and the provider.
- The client must complete the W-9 form. The W-9 form can be found in the Appendix.
- Scan the W-9 form in and email to InHomeHealthDemographic@dhs.state.ia.us
- Enter the service plan and client participation in IoWANS.
- Answer milestones in IoWANS to approve the service plan.
- IM will determine the financial eligibility.
- Explain billing procedures, responsibilities, and limitations of the program to the client and provider.
- Discuss termination procedures and time limits with the client and the provider.
- Write the case plan using form 470-0583, *Individual Service Plan*.
- Submit copies of form 470-0636, *Provider Agreement*, and a copy of the case plan, including health care plan, to service area manager (or designee) for approval.
- When the service area manager (or designee) returns the signed form 470-0636, *Provider Agreement*, file one copy in the HHS service file and mail copies to the client and provider, along with form 470-0602, *Notice of Decision: Services*, approving service. Clarify who will receive the client participation, the amount, and the type of service.

Approval (Cont.)	▪ Before sending copies of form 470-0636, *Provider Agreement* to the client and provider, use black marker pen to redact the client's Social Security number. ▪ Give each provider an adequate supply of form 470-0648, *Statements of Services Rendered*, and self-addressed stamped envelopes to mail to the assigned HHS service worker.
Case Maintenance	
Monthly Billing	▪ Upon receipt of form 470-0648, *Statement of Services Rendered*, from the client. Enter the invoice information in IoWANS. ▪ Attach form 470-0648, *Statement of Services Rendered*, to the printed invoice page from IoWANS and place in the service case file.
Case Review	
Quarterly Review	▪ Review the entire care plan at least once every three months/90 days. If the client has an MCO Case Manager or supervising practitioner, this review should include a consultation. Document this review in the narrative.
Semiannual Review	▪ The physician reviews the need for continued in-home health care services and provides a written recertification of the continuing appropriateness of the care plan required every 180 days, upon initiation of Medicaid waiver services, or more frequently as decided upon by physician or IHHRC service worker.
Scheduled Supervising Practitioner Review	▪ **If skilled services are needed,** the supervising practitioner will set schedule for reviewing skilled services as documented on page 3 of form 470-0673, *Physician's Report/Health Care Plan*. This review will occur either every 60 days, every 90 days, or every 180 days.
Annual Review	▪ Review and reassess all eligibility factors by conducting a home visit once per year, minimum, and completing all paperwork requirements, including form 470-5602, *Service Worker Comprehensive Assessment*. ▪ Assist the client in completing form 470-5482 or 470-5482(S), *Medicaid/State Supp Review*, if needed. The IM worker sends this form to the client when it is time for the review.

Annual Review (continued)

- Remind the client to obtain the required annual physician's physical examination. Provide form 470-0673, *Physician's Report/Health Care Plan*, to the client.
- Have the client sign a current form 470-3951, *Authorization to Obtain or Release Health Care Information*, for the physician and supervising practitioner (if necessary)
- If skilled services are needed, ensure the supervising practitioner has reviewed and signed form 470-0673, *Physician's Report/Health Care Plan* after completed by physician
- Have the provider sign a current form 470-3951, *Authorization to Obtain or Release Health Care Information*.
- Obtain a new form 470-0672, *Provider Health Assessment* from provider.
- Send *Notice of Decision: Services*, form 470-0602 or 470-0602(S), clarifying how much client participation is paid to each provider for which service.
- If the provider changes, terminate the *Provider Agreement* and complete the required steps for approving another provider.
- Notify the IM worker of any changes either by email or entries in IoWANS, such as case termination and note reason.

Determining Eligibility

Legal reference: 441 IAC 177.4(249)

A person must meet the following requirements to be eligible for in-home health-related care (IHHRC):

- The person must be eligible for SSI in every respect except income, and
- The person must be certified by a physician as requiring skilled or personal care services and those services can be provided in the person's own home, and
- The person must be living in the person's own home.

NOTE: "Own home" means a person's house, apartment, or other living arrangement intended for single or family residential use. A person is considered to be living in the person's own home even though the person may be sharing the household of another. Such arrangements may be temporary or permanent and may be established for the purpose of providing health care.

Instructions for determining eligibility are divided into four sections:

- Communicating with income maintenance
- Taking applications
- Pending applications
- Assessing services needs

Communicating with Income Maintenance

Use the comment section in IoWANS or email to communicate with the IM worker as to what is happening in the case. Examples of communication may include notice of service eligibility, payments issued, and case closure.

Communication may also include the use of email to inform the IM worker of such things as:

- The client's living arrangements and/or address have changed.
- The client has died.
- The client is no longer receiving the service.
- The service worker has a new application.
- Payment for services has begun.

Examples of times when the IM worker would use IoWANS or email to communicate with the service worker:

- The amount of client participation on a new case has been determined.
- The client becomes eligible to receive Medicaid.
- The client's income has increased or decreased.
- The client participation has increased or decreased.
- The client's address has changed.
- The client is financially ineligible for services.

Taking Applications

Legal reference: 441 IAC 177.4

The client, or a responsible person acting on behalf of the client, may apply for services at the local office of the Department. The initial application can be submitted to either the service worker or the IM worker.

If received by a service worker, review the demographic information for accuracy and forward the application to income maintenance.

Form 470-5170 or 470-5170 (S), *Application for Health Coverage and Help Paying Costs*, is the application for both medical and service components of the in-home health-related care program. Keep the signed application in the IM case file. It is not required that a copy of the *Application for Health Coverage and Help Paying Costs* be kept in the HHS service case file.

NOTE: The *Application for Health Coverage and Help Paying Costs* serves the purpose of the *Application for All Social Services*, form 470-0615 or 470-0615(S). It is not necessary for the client to sign the *Application for All Social Services* also.

During the application process, the service worker determines if service criteria as defined in this chapter are met and determines the value of the home health care the client will require.

A Department IM worker is responsible for determining financial eligibility. The service worker will receive notice from the IM worker as to whether the client is initially financially eligible and if client participation is required in IoWANS.

If the client's income is above SSI standards, the IM worker determines the amount of countable income and resources based on policies in 6-B, *Resources*, and 8-E, *Income Policies for SSI-Related Coverage Groups*.

Countable income may be from any source: Veterans Administration, Railroad Retirement, Social Security, pension, interest, farm, etc.

If income is below SSI standards and the client is not receiving SSI, it is essential that the client, the client's legal representative, or a responsible party immediately complete an application at the Social Security Administration office, so SSI eligibility can be established. (Application for other benefits is an eligibility factor for State Supplementary Assistance.)

Pending Applications

Legal reference: 441 IAC 177.4

Complete the eligibility determination within 30 days from the date of the application, unless one or more or the following conditions exist:

- An application for Supplemental Security Income (SSI) benefits is pending.
- The receipt of information, which is beyond the control of the client or the Department, has not yet been received.
- A disability determination is pending.
- Form 470-0636, *Provider Agreement*, has not yet been received.

NOTE: Communicate any delays due to the above reasons to IM by email.

EXCEPTION: The 30-day timeframe can be extended to 60 days if a provider cannot be located within 60 days from the date of application.

The client may reapply when a provider is located.

Assessing Service Needs

Legal reference: 441 IAC 177.7

In-home health-related care can be provided only when other existing programs cannot meet the client's needs. A person cannot receive the same service from in-home health-related care (IHHRC) and another Medicaid program at the same time. A person who is eligible for more than one Medicaid program that can provide the same service must select the most cost-effective program to meet the client's needs. The HHS service worker is responsible for determining if the needed services can be met through programs other than IHHRC. A client's right to self-determination is paramount. You cannot mandate that a client apply or accept waiver or any other service.

- A client can be on IHHRC and waiver services at the same time.
- A client can be on habilitation waiver and another waiver at the same time.
- A client can receive IHHRC and be enrolled with an integrated health home.

IHHRC should not duplicate any service provided under waiver (including habilitation waiver). If a service is being provided under another source (including waiver, IHHRC should not be providing the same service.

1. Make an initial assessment of the client's physical and emotional health care needs and protective needs, based on all available information including information from other professionals (e.g., physician, public health nurse) and the completed Service Worker Comprehensive Assessment, form 470-5602.

2. Make the initial determination that the client's needs can be met by an in-home program, and cannot be adequately met by other community programs, including:
   - Homemaker-health aide program
   - Visiting nurse services
   - Chore service
   - Medicaid waiver programs
   - Service organizations
   - County-funded programs
3. Consult the physician to determine the health care needs of the client. The physician must make the determination of whether or not the client needs the service and whether or not the client's health care needs can be met with this service. The physician must complete form 470-0673, *Physician's Report/Health Care Plan.*
4. **If skilled services are a part of the service need,** services must be supervised by a supervising practitioner (physician, nurse practitioner, clinical nurse specialist or physician's assistant). Consult with supervising practitioner regarding the personal, nursing, and medical care required by the client, the qualifications of the provider, and the amount of supervision the practitioner will provide.
5. Assist the client and family with obtaining the necessary health care services, as stated in form 470-0673, Physician's Report/Health Care Plan. The identified health care services can include a registered nurse, licensed practical nurse, homemaker-home health aide, or volunteers (family or otherwise) to be trained by a professional, either from another agency or private providers.
6. Help the client inform these persons about how the program will operate, including payment procedures, and provide overall coordination of the health care services with other services being provided to the client, e.g., chore service, mobile meals, homemaker, etc.
7. If the client is being transferred from a hospital or nursing facility, obtain a transfer form describing the client's current care plan, to be provided to the supervising practitioner in the event the care plan contains skilled service needs.

Planning Services

This section covers the actions necessary to move from the assessment of service need to developing a plan for using the in-home health-related care (IHHRC) program to meet the client's assessed needs. It is organized in the following parts:

Available Services

Legal reference: 441 IAC 177.3(249)

The in-home health-related care (IHHRC) program includes both skilled and personal care services, as follows:

- Skilled services include **skilled nursing services** or other services that based on a physician's certification, are required to be performed under the supervision of a physician, nurse practitioner, clinical nurse specialist or physician's assistant
- Skilled nursing services are services which an individualized assessment of a patient's clinical condition demonstrate that the specialized judgment, knowledge and skills or a registered nurse, or when provided by regulation, a licensed practical (vocational) nurse ("skilled care") are necessary.
- Skilled services may include, but are not limited to:
  - Gavage feedings (tube feeding of person unable to eat solid food).
  - Intravenous therapy administered only by a registered nurse.
  - Intramuscular injections, (excluding diabetes).
  - Catheterizations, including continuing care of in dwelling catheters with supervision of irrigations and changing of Foley catheter when required.
  - Inhalation therapy.
  - Care of decubiti and other ulcerated areas (requires noting and reporting to physician).
  - Rehabilitation services, which include, but are not limited to: bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, teaching the activities of daily living, respiratory care and breathing programs, remotivation, and behavior modification.
  - Tracheotomy care.
  - Colostomy care, until the person is capable of maintaining the colostomy personally.
  - Care of uncontrolled types of medical conditions, brittle diabetes/terminal conditions.
  - Post-surgical nursing care for short time periods, primarily for persons with complications following surgery, or with the need for frequent dressing changes.
  - Monitoring medications when there is a need for close supervision of medications because of fluctuating physical or mental conditions, such as hypertensives, digitalis preparations, or narcotics.
  - Need for therapeutic diets. Evaluation of diet at frequent intervals.
  - Recording and reporting change in vital signs to the attending physician.
- Other technical procedures may be assigned at the discretion of the supervising practitioner, based on evaluation of the training, experience, and ability of the provider.

- Personal care services are services that:
  - Assist a client with the activities of daily living, such as, but not limited to helping the client with bathing, toileting, getting in and out of bed, ambulation, hair care, oral hygiene and administering medications that are physician ordered but ordinarily self-administered.
  - Help or retrain the client in necessary skills for daily living.
  - Provide incidental household services that are essential to the client's healthcare at home and are necessary to prevent or postpone institutionalization.
- Personal care services do not require a supervising practitioner. Personal care services may include, but are not limited to:
  - Supervision on a 24-hour basis for physical or emotional needs. This may include the use of volunteers or non-paid family, as well as the service provider, but only the cost of the health care provider will be included.
  - Helping client with bath, shampoo, and oral hygiene.
  - Helping client with toileting.
  - Helping client in and out of bed and with ambulation.
  - Helping client to reestablish activities of daily living.
  - Assisting with oral medications.
  - Performing incidental household services that are essential to the client's health care at home and are necessary to prevent or postpone facility care.

Requirements for Skilled Services

Legal reference: 441 IAC 177.8 (249),

The physician's certification as noted on form 470-0673, *Physician's Report/Health Care Plan* will include a health care plan which includes the specific types of services required, the method of providing those services, and the expected duration of the services.

If skilled services are part of the service need, services must be supervised by a physician, nurse practitioner, clinical nurse specialist or physician's assistant. This supervising practitioner is responsible for providing instruction to the IHHRC care provider specific to the IHHRC client. Instruction should include, but is not limited to, instruction on documentation the IHHRC care provider is responsible for as well as instructions on warning signs of which the IHHRC care provider should be aware.

The supervising practitioner will obtain from the client's physician or the service worker form 470-0673, *Physician's Report/Health Care Plan* that has been completed by the physician. The supervising practitioner will complete page 3 of form 470-0673, *Physician's Report/Health Care Plan,* and shall set up a schedule for reviewing documentation that is specific to the services being provided to the specific IHHRC client.

The supervising practitioner is responsible to keep appropriate medical records, a copy of the service plan, and the completed form 470-0673, *Physician's Report/Health Care Plan* in their case file. The medical records shall include the following items whenever appropriate:

- Transfer forms
- Physician's certification and orders
- Progress notes
- Drug administration records
- Treatment records
- Incident reports

The Department may review medical records related to the In-Home Health-Related Care program.

Individual Service Plan

Legal reference: 441 IAC 177.7(1)

The service worker will develop an individual client case plan using form 470-0583, *Individual Service Plan*. Include in the plan:

- **Assessment**: Include a summary of the client's current home situation, informal supports, need for services, and other services the client is currently receiving.
- **Income Information**: Source of income.
- **Goals**: List the goals of the plan.
- **Objectives**: List the objectives of the plan.
- **Specific Services**: List the services the client will be receiving through the In-Home Health-Related Care (IHHRC) program and any other formal and informal services that the client is receiving.
- **Responsibilities**: List the responsibilities of the client, provider, and the service worker.
- **Reassessment/Termination**: Note if this is a reassessment or termination. If reassessment, update the information above. If termination, explain the reason for termination.

The individual client case plan should include a comprehensive outline of all service needs and plans for meeting those needs. When preparing the plan, take into consideration:

- Whether needed services can be met through existing programs including, but not limited to:
  - Homemaker-home health aide programs
  - Visiting nurse services
  - Medicaid waiver programs
  - Service organizations
  - County-funded programs
- That the cost of service paid for under this program cannot exceed the base SSI allowance plus the service cost.

NOTE: The service worker is responsible for determining if the needed services can be met through programs other than IHHRC. Do not use this program in place of valid referrals for homemaker, a waiver service, etc.

NOTE: The service plan documented on form 470-0583, *Individual Service Plan*, the description of specific duties on form 470-0636, *Provider Agreement*, and the service plan entered in IoWANS must match.

Amount of Supplementation

Legal reference: 441 IAC 51.2(249)

The HHS service worker determines the person's services and the cost of those services. The IM worker determines financial eligibility and the amount of client participation in the service cost. When the IM worker has transmitted that information to the service worker through IoWANS, the maximum dollar amount per month the client is eligible to receive through this program can be determined.

The amount of supplementation is the difference between the cost of the service and the amount of client participation, up to the current maximum cost per month for each person needing care. The costs must be justified by the service plan.

The current maximum payment per month is $480.55.

The IM worker determines eligibility based on the family's gross income. After eligibility is determined, all other income available to the client is considered in determining client participation, with applicable disregards. Some of these disregards are:

- Chapter C(6): In-Home Health-Related Care Services Planning Services
- Revised February 17, 2023 Amount of Supplementation
- The amount of the basic SSI income standard for an individual or a couple living in their own home and for any dependents:
  - For an individual $914.00
  - For a couple $1,371.00
  - For each dependent, add $457.00
- When income is earned, $65 plus one-half of the remainder.
- Diversion for established unmet medical needs of the client, the spouse, and any dependents.

"Established unmet medical needs" include costs such as visits to physicians, prescription medicines, and related travel expenses needed on an ongoing basis and not covered by insurance or Medicaid. Insurance premiums and unmet past bills are not included.

Any income remaining after the disregards is applied toward service costs under this program before beginning supplementation. See 6-B, *In-Home Health-Related Care* for a complete discussion of income eligibility and client participation policies for adults and children.

Then the potential supplementation is figured up to the maximum service cost.

1. Mr. A has unearned income (SS, VA, etc.) totaling $1,200 per month and unmet medical needs of $100 per month. He must pay the first $186 of service [($1,200 - $100) - $914]. No supplementation is available to Mr. A if his total service need is $186 or less.
2. Mr. and Mrs. B have unearned income (SS, VA, etc.) totaling $1,750 per month, with no unmet medical needs. They must pay the first $379 of service costs ($1,750 - $1,371). No supplementation is available to Mr. and Mrs. B if their total service need is $379 or less.
3. Mr. and Mrs. C have earned income of $3,500 gross per month and unmet medical needs of $50. Only Mr. C needs care. The first $65 earned income is disregarded plus half of the remainder. The couple's adjusted monthly income is $1,717.50 [($3,500 - $65) ÷ 2]. They must pay the first $296.50 of service [($1,717.50 - $50) - $1,371]. No supplementation is available to Mr. C if his total service need is $296.50 or less.

If the first month of service for a person receiving in-home health-related care is less than a full month, there is no required client participation for that month. The program will pay for the actual days of service provided according to the agreed-upon rate.

Client participation can be split between more than one service and more than one provider. When developing the *Provider Agreement*, identify who will receive the client participation with the client and providers.

Once approved, IHHRC services may be paid from the date of application or the date all eligibility requirements are met, whichever is later.

Qualifications of Service Providers

Legal reference: 441 IAC 177.5(249)

The primary responsibility for locating a provider is with the client or the client's family, however, the service worker may assist if needed.

All providers of service under this program must meet the following criteria:

- The provider shall be at least 18 years of age.
- The provider must have a valid Medicaid provider number.
- The provider shall obtain a health assessment report at the beginning of the service and annually thereafter. A physician, advanced registered nurse practitioner or physician assistant working under the direction of a physician shall complete form 470-0672, *Provider Health Assessment.*
- Providers shall have the training and experience necessary to carry out the service plan. **If skilled services are a part of the service plan**, the supervising practitioner approves the provider's training and experience. The Department assumes no liability for the actions of any of the providers, professional or nonprofessional.

- The provider may be related to the client, as long as the provider is not a member of the family. "Family" means:
  - Legal spouses (including common law) who reside in the same household.
  - Natural, adoptive, or step mother or father, and children (under 18) who reside in the same household.
  - An individual or a child who lives alone or who resides with a person or persons not legally responsible for the child's support.
- A temporary absence does not change the composition of the family. When adults other than spouses reside together, each is considered a separate family.

  NOTE: A spouse, including common law spouse, should not be the provider to the client. An ex-spouse may be a provider so long as HHS has a copy of the divorce decree.

  NOTE: The supervising practitioner cannot be a care provider for the specific IHHRC client for which they are supervising services.

  NOTE: An agent under a health care power of attorney cannot be a care provider for the specific IHHRC client which is the principal in a healthcare power of attorney pursuant to Iowa Code 144B.4

Reasonable Charges

Legal reference: 441 IAC 177.10(249)

Determine reasonable charges for payment of IHHRC service by:

- Prevailing (usual and customary) community standards for cost of similar services.
- Availability of service providers at no cost to the Department.

Agreements for Service

Legal reference: 441 IAC 177.9(249)

Before provision of service, ensure the client and each IHHRC care provider negotiate a *Provider Agreement*, form 470-0636, as found in the Appendix. The *Provider Agreement* includes a statement of the work to be performed, the rate of payment in 15-minute increments, and the maximum monthly payment allowed. The distribution of client participation should also be identified at this time.

Discuss with providers (individuals and agencies) their responsibilities and liabilities, including discontinuance of payment upon termination of service.

Form 470-0636, *Provider Agreement* will include written instructions for dealing with emergency situations. Include any instructions that might be contained in form 470-0673, *Physician's Report/Health Care Plan*. The emergency instructions will include:

- The name and telephone number of the client's:
  - Physician
  - Supervising Practitioner (if applicable)
  - Family members or other significant person
  - IHHRC service worker

- Information as to which hospital to use.
- Information as to ambulance service or other emergency transportation to use.

The provider of services under this agreement is not considered an agent, employee, or servant of the state of Iowa, the Department of Health and Human Services, or any of its employees. It is the provider's responsibility to determine employment status in regards to income tax and social security. Providers of service have no recourse to the Department to collect payments due as a result of this agreement.

Discuss the termination procedures and time limits with the client and provider.

Each provider must have a valid Medicaid provider number in the IoWANS system. Before entering provider demographic information search IoWANS to determine if the provider has a Medicaid provider number. If the provider does not have a traditional provider number, IoWANS will generate a non-traditional provider number upon entry of all required fields.

A client must have a separate Form 470-0636, *Provider Agreement* for each provider the client is using.

A provider that has more than one client must have a different *Provider Agreement* for each client. If the provider has more than one client, the provider will have the same provider number for each client.

To change anything on a *Provider Agreement*, complete a new form and check "Amendment." See Monitoring and Changing Services: Amending the Provider Agreement.

Requesting Approval

The service area manager (or designee) approves the in-home health-related care service program by signing the *Provider Agreement*, form 470-0636. Send the following to the service area manager (or designee) for approval:

- A copy of the completed form 470-0583, *Individual Client Case Plan*,
- A copy of completed form 470-0673, *Physician's Report/Health Care Plan*,
- Three copies of the *Provider Agreement*, form 470-0636.

A signed *Provider Agreement*, form 470-0636, returned to the assigned service worker constitutes program approval and approval for payment.

Distribute copies of the *Provider Agreement* to the client and the provider. Place the original in the HHS service case file.

When the agreement is approved, give each provider an adequate supply of form 470-0648, *Statement of Services Rendered*, with self-addressed stamped envelopes to mail to the assigned service worker.

Notification

Legal reference: 441 IAC 7.4(4)

Notify the client of approval, denial, or termination of service and when changes occur, using form 470-0602, *Notice of Decision: Services* located in the Appendix. Include in the *Notice of Decision: Services* the following:

- A statement of what action is being taken.
- The reasons for the intended action.
- The manual chapter number and subheading supporting the action, along with the Iowa Administrative Code reference.
- The amount of client participation, if any, and the distribution of client participation.

  NOTE: For approvals, the *Notice of Decision* can be generated by IoWANS, but does not have the ability to be altered with additional information.

Information entered into IoWANS will alert the IM worker to:

- The approval and certification of case plan.
- The maximum amount of payment approved.

Denial of Service

Legal reference: 441 IAC 51 (177)

If the client is ineligible to receive State Supplementary Assistance because the income or resources exceed the program maximum limits or the client did not provide financial information, the IM worker will deny the application and sends form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance* or *470-0485, Notice of Decision (IABC generated)* or *470-0485 Notice of Action (ELIAS generated)* to the client. **If the client is denied based upon IM procedures, the service worker does not need to do a separate Notice of Decision.**

If the client is ineligible for any other reason, the service worker will then deny the application and send form 470-0602, *Notice of Decision: Services* stating the reason for the denial. Reasons include one of the following:

- The client is ineligible because the client participation exceeds the cost of care.
- The client does not need supplementation to meet the cost of care.
- The physician does not approve the in-home health care plan.
- An appropriate provider cannot be located within 60 days from the date of application.
- Other programs or services available in the community can meet the client's needs.

Eligibility for Medicaid

Legal reference: 441 IAC 75

Most recipients of State Supplementary Assistance are eligible for Medicaid. The IM worker makes that determination. Eligibility is reviewed at least annually. When the client is eligible for Medicaid, the IM worker issues the *Notice of Decision or Notice of Action* to the client.

NOTE: **Never** approve a client to receive in-home health-related care solely for the purpose of obtaining Medicaid coverage.

Processing Payments

Legal reference: 441 IAC 177.7(3)

IoWANS is the computer system that provides the means to enter the service plan information and the invoice to generate payment for IHHRC services.

The provider and the client complete form 470-0648, *Statement of Services Rendered* and submit it to the assigned service worker.

The service worker completes the invoice on IoWANS for all IHHRC providers that have submitted a signed *Statement of Services Rendered*. Complete only one invoice per month for each agreement.

Do **not** enter an invoice until **after** the month is over. The first day an invoice may be entered is the first day of the following month.

The client is the sole payee for payments made under this program. The client is responsible for making payment to the provider, except when either of the following circumstances applies:

- One payment may be made to the provider on behalf of a client who dies or becomes incapacitated while receiving services.
- The client has a legally designated person to handle finances, such as a court-appointed conservator, a representative payee established by the Social Security Administration, or an agent under a financial power of attorney agreement. See Adding Or Changing a Payee for more information.

After entering the invoice information in the IoWANS system, attach the *Statement of Services Rendered* to the printed invoice screen from IoWANS and file in the client's service file.

NOTE: To avoid potential payment issues enter all agreement information into IoWANS at least two weeks before entering the invoice in IoWANS.

Maintain the original invoices in the local office for the current fiscal year plus the next fiscal year. Invoices may then be sent to record storage for an additional three years using reference # BUD 2-10-1, Accounts Payable Records. (*RECORDS MANAGEMENT MANUAL*, Records Retention and Disposition Schedule BUD.)

The following sections provide additional information on:

Authorized Payment Reduction

When the Department authorizes a payment reduction, have the IHHRC car provider and client complete an amendment *to Provider Agreement*, form 470-0636, found in the Appendix.

NOTE: "Amendment" must be checked in the upper right hand corner of the form. Have both the IHHRC client and care provider sign the form. This will verify that the client and provider have been made aware that the payment will be reduced.

Direct Deposit

A client who wishes to have the IHHRC payment deposited directly into a bank account must complete a *Direct Deposit Authorization* form authorizing direct deposit into the client's account. Submit the *Direct Deposit Authorization* form to the Iowa Department of Administrative Services. The *Direct Deposit Authorization* form can be found in the manual Appendix.

A client who wishes to cancel the Electronic Funds Transfer (EFT) authorization and revert to the state paper warrant (check) for the IHHRC payment needs to complete the *Direct Deposit Authorization* form and check "Cancel" in the top right corner. The form can then be returned to the Bureau of Purchasing, Payments, Receipts and Payroll by mail or email (InHomeHealthDemographic@dhs.state.ia.us).

Payments made by direct deposit usually appear in the account the third business day after payment issuance. Payments issued via direct deposit cannot be cancelled after payment is issued (like the warrant is cancelled). In the event of an overpayment or adjustment, the funds must be repaid by check or money order.

Remedying Payment Issues

Canceling a Payment to Get a Duplicate Warrant

When you cancel a payment, you will get a *duplicate* payment the way it was originally issued (same name/same payee/same amount). Canceling a payment results in a *duplicate* payment be re-issued. The payment is cancelled when the original payment is lost and an exact copy needs to be issued. We can have a duplicate payment sent to a different address (manually addressed) if the person moved and the address doesn't match, but we cannot change the names on the payment. Cancel is done by fiscal in the I/3 database if payment is no longer valid.

Checks are only valid for 6 months. A duplicate payment can be issued for an original payment that has not been redeemed after 10 days. When a duplicate payment is issued, it renders the original payment null and void.

To cancel a payment and get a duplicate payment issued, complete form SAE0120, *Request for Warrant Action*, and send to the Bureau of Purchasing, Payment, and Receipts. The form and its instructions can be found in the manual Appendix.

Canceling a Payment Before It Is Issued

Use the cancel/delete function in IoWANS only when you are creating a payment and there is an error. The cancel/delete function exits the worksheet abandoning all entries made. The cancel/delete function must be done before 5:00 PM on the same day as the payment is entered.

Voiding a Payment to Change Payment Details

When there is something wrong with the payment (amount is wrong/address is wrong/payee is wrong), you need to void the payment to have an altered payment issued. While voiding a payment might be necessary, try to avoid voiding payments if at all possible because this creates a manual audit file. The payment should only be voided and re-issued when something about the payment has changed (payee or the amount) *and we have the original payment in hand.*

Prior to having a new payment issued, the service worker should fix any incorrect information related to the case.

- If information in IoWANS needs corrected, use form 470-3923, *Request for Medicaid Services Data Changes and Verification* and send to the IoWANS helpdesk at IoWANSHelpDesk@dhs.state.ia.us
- If information on the W-9 needs corrected, use form W-9 and send to InHomeHealthDemographics@dhs.state.ia.us
- Notify and request the IM worker to change address and name information in IABC/ELIAS.

Once the corrections have been made to the appropriate databases, the service worker can void a previous invoice and create a new invoice for those same service dates in IoWANS.

Removing the payee is a valid reason for voiding the payment. See Adding or Changing a Payee on steps to add or change the payee before getting a payment reissued.

Fixing an Underpayment

If an underpayment occurred due to a clerical error, the service worker can email the Bureau of Purchasing, Payments, and Receipts in order to issue a second check to the client to total the maximum payment (both checks cannot exceed $480.55). The service worker should send a detailed email outlining the request to the Bureau of Purchasing, Payments, and Receipts with that payment's Statement of Services Rendered (form 470-0648). The service worker will also provide the Vendor Customer ID which can be found in IoWANS.

Warrant Returns

Any warrants returned to the Department's central office from the client will be kept in the Bureau of Purchasing, Payments, Receipts and Payroll until the service worker can verify the address. When the address is verified and corrected, the Bureau will mail the warrant again.

If the warrant cannot be delivered, this could be due to several reasons. Ensure the correct address is displaying on IoWANS. Contact the Bureau of Purchasing, Payments and Receipts to make sure the correct address is displaying in the I/3 database by emailing InHomeHealthDemographic@dhs.state.ia.us

Notify the IM worker of the correct address information to be entered into IABC/ELIAS and uploaded into IoWANS.

Client Has Died or Is Incapacitated

Legal reference: 441 IAC 177.4(1)

When a client dies or becomes incapacitated:

1. Complete an amended Provider Agreement reflecting the client's changed condition and listing the provider as the payee. (you do not need documentation of payee status to have this one-time payment issued).
2. Change the client's name and address to the provider's name and address. Leave the provider's information. Change the social security number to the provider's social security number.
3. Complete a new W-9 with the provider's information. Keep a copy in the HHS service case file.
4. Submit the original statement of services rendered (signed by the provider) and the new W-9 form to the address below.

   Department of Health and Human Services
   Bureau of Purchasing, Payments, Receipts and Payroll
   1305 E. Walnut St.
   Des Moines, Iowa 50319-0114
5. If a warrant was issued to the client, make a copy for the service file, then return the check to central office at the address:

   Department of Health and Human Services
   Bureau of Purchasing, Payments, Receipts and Payroll
   1305 E. Walnut St.
   Des Moines, Iowa 50319-0114

NOTE: This is a one-time only procedure. If an incapacitated client will remain in the program, assist the client's family to have a person legally designated to handle the client's finances and become payee on behalf of the client. See Adding Or Changing a Payee for instructions.

Monitoring and Changing Services

Legal reference: 441 IAC 177.7 and 441 50.4

The IHHRC service worker, physician, supervising practitioner, or the provider may request a review of the care services at any time. While more frequent reviews may be held, at a minimum, a review of the continuing need for IHHRC services should occur at the following intervals:

- Monthly/Every 30 days:
- The service worker shall review form 470-0648, *Statement of Services Rendered* submitted by the IHHRC client and IHHRC care provider. The service worker will enter invoice information in IoWANS to render payment for services rendered. If there are concerns upon such a review, a change in the service plan will result.
- Bimonthly/Every 60 days:
  - **If skilled services are needed** and the supervising practitioner set a schedule for reviewing skilled services as documented on page 3 of form 470-0673, *Physician's Report/Health Care Plan* as every 60 days.
- Quarterly/Every 90 days:
  - The service worker shall review the entire care plan at least once every 3 months/90 day. If the IHHRC client has an MCO Case Manager or supervising practitioner, this review should also include a consultation. Document this review in case narrative.
  - **If skilled services are needed** and the supervising practitioner set a schedule for reviewing skilled services as documented on page 3 of form 470-0673, *Physician's Report/Health Care Plan* as every 90 days.
- Semiannually/Every 180 days:
  - The physician reviews the need for continued in-home health care services and provides a written recertification of the continuing appropriateness of the care plan required every 180 days, upon initiation of Medicaid waiver services, or more frequently as decided upon by physician or IHHRC service worker.
  - **If skilled services are needed** and the supervising practitioner set a schedule for reviewing skilled services as documented on page 3 of form 470-0673, *Physician's Report/Health Care Plan* as every 180 days.
- **Annually**: Review the entire care plan annually.
  - Complete a new case plan annually.
  - Form 470-5482, *Medicaid/State Supp Review* will be automatically sent to the client. This form serves the same function as form 470-5170, *Application for Health Coverage and Help Paying Costs*. Upon receipt of the *Medicaid/State Supp Review* the form will be kept in the IM case file.

    NOTE: Failure of the client in returning the Medicaid Review form could result in IHHRC ineligibility and termination.
  - Have the IHHRC care provider sign a current form 470-3951, *Authorization to Obtain or Release Health Care Information*. Have the provider complete a new *Provider Health Assessment*, form 470-0672.

- Have the client sign a current form 470-3951, *Authorization to Obtain or Release Health Care Information*, for the physician and supervising practitioner (if necessary)
- Request an updated *Physician's Report/Health Care Plan*, form 470-0673. File them in the HHS service case file.
- Complete a new *Service Worker Comprehensive Assessment*, form 470-5602.
- Update the *Provider Agreement*, form 470-0636, reviewing client participation payments.

Document each review in the narrative section of the HHS service case file.

NOTE: Upon initiation of Medicaid waiver services, the physician is required recertify the client's service needs by reviewing the certification and withdraw, renew or amend the existing certification. The service worker is required to review and complete a new service plan to determine if continuing IHHRC services are warranted. Consultation is required with the MCO case manager.

It can take 2-3 months after being approved for waiver for wavier services to start. If care needs are being fully met by services provided under waiver, end IHHRC services when wavier services have started.

- MCO Case Manager contact information can be obtained from IMPA database system.
  - Under File Tab, click on MCO-Member Lookup
  - Enter state ID of member
  - Click program/services tab
  - Click LTC case record

Amending the Provider Agreement

To change anything on the *Provider Agreement*, form 470-0636, (other than client and provider name) fill out a new form, but check "amendment."

An amendment is required when there is a Department authorized reduction, client participation changes, or the client dies or becomes incapacitated.

An amendment cannot be used when there is a change regarding a client or a provider. There must be a new *Provider Agreement* when there is a new client or a new provider.

If a provider has more than one IHHRC client, the provider must have a different form 470-0636, *Provider Agreement* for every IHHRC client. A client and a provider could each have more than one valid *Provider Agreement*. Each of the client's providers would have a different Medicaid provider number. The IHHRC care provider's Medicaid provider number would be the same for each client they serve.

When a client dies or becomes incapacitated while receiving services and the client is the payee, an amendment should be prepared listing the provider as payee for a single payment. See Client Has Died or Is Incapacitated.

The instructions are the same for each line item as those for the agreement. See the Appendix for form instructions.

To change form 470-0636, *Provider Agreement*, complete items in all sections and check "yes" for amendment.

The following items may be amended with no client or provider signature:

- Addresses and phone numbers
- Incorrect social security number
- Maximum payment if it is increased
- Addition of or change in a payee
- Unit cost, if increased
- Termination date, if the client has requested termination, has died, or has entered a long-term care facility

The following amendments require client and provider signatures:

- Decrease in unit cost
- Decrease in maximum payment per month
- Change in client participation
- Termination date that is adverse to the client (Death or client move out of home does not require signature)
- Renewal of agreement for the next time period (List new beginning and termination dates.)

Send the agreement amendments to the service area manager (or designee) for signature. When the signed *Provider Agreement* is returned from the service area manager (or designee), enter the changes in IoWANS.

Adding or Changing Providers

When a new provider begins:

1. Ensure the provider has a valid Medicaid provider number.
2. Explain the billing procedures, responsibilities, and limitations of the program to the new provider.
3. Have the IHHRC care provider sign a current form 470-3951, *Authorization to Obtain or Release Health Care Information*. Give the provider form 470-0672, *Provider Health Assessment,* to be completed by a physician, advanced registered nurse practitioner, or a physician assistant working under the direction of a physician.
4. Complete a *Provider Agreement*, form 470-0636, with the new provider and the client.
5. Submit three copies of the *Provider Agreement* to the service area manager (or designee) for approval.
6. When the service area manager (or designee) returns the three copies of the signed *Provider Agreement*, file the original copy and mail one each to the client and the provider. Before sending copies of the *Provider Agreement* to the client and provider, use a black marker pen to redact the client's social security number.
7. Give the new provider an adequate supply of form 470-0648, *Statement of Services Rendered*, and self-addressed stamped envelopes to mail to the assigned service worker.

8. **If skilled services are a part of the service plan,** notify the supervising practitioner of the new provider and change the name of the provider on the case plan.

When a *Provider Agreement* is canceled before the expiration date:

1. End the service line for that provider in IoWANS.
2. Complete a new *Provider Agreement*.
3. Enter new service line or lines in IoWANS for the new provider.
4. Send a notice of decision to the client and the provider.

To inactivate the provider in IoWANS:

1. Manage nontraditional provider.
2. Enter provider number and then enter the Update button.
3. Change provider status to "other state termed."
4. Enter new enrollment status date.

Adding or Changing a Payee

In order to add or change a payee, we need documentation verifying the payee relationship. Payee documentation can include but is not limited to: Social Security Administration award letter for payee, court order for conservator, or financial power of attorney agreement.

Documentation must first be provided to the IM worker for the payee to be added into IABC/ELIAS and IoWANS. The IM worker can be noted on the role screen in IoWANS.

After the change has been made to IABC/ELIAS and IoWANS, provide the documentation to the Bureau of Purchasing, Payments and Receipts. Purchasing, Payments and Receipts must have a copy to add the payee to the I/3 account.

Once all of the changes have been made by IM and the Bureau of Purchasing, Payment and Receipts, the service worker can VOID the old invoice and create a NEW invoice for those same service dates in IoWANS.

The service worker will need to send the old uncashed check/invoice into Purchasing, Payments, & Receipts. A copy of the new invoice along with a request that the old invoice be cancelled noting the amount will be paid on the new invoice.

A payment will generate with the correct information (because you will have already corrected I/3).

Terminating Services

Legal reference: 441 IAC 177.11 (249)

Terminate in-home health-related care service under the following conditions:

- Upon the request of the IHHRC client or legal representative (441 IAC 177.11(1)).

  If termination of the program would result in the client being unable to protect the client's own interests, provide assistance with making any necessary arrangements to ensure the client's needs will be met in a safe environment.
- When the client becomes sufficiently able to remain in the client's own home with services that can be provided by other sources as determined by the HHS IHHRC service worker (441 IAC 177.11(2))
- When the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the HHS IHHRC service worker in consultation with the certifying physician (441 IAC 177.11(3))
- When the cost of care exceeds the maximum established in subrule 177.10(3) (441 IAC 177 11(4))
- When the HHD IHHRC service worker determines that other services can be utilized to better meet the client's needs. (441 IAC 177.11(5))
- When it has been determined by the HHS IHHRC service worker that the terms of form 470-0636, *Provider Agreement*, have not been met by the client **or** the provider. (441 IAC 177.11(6))
- When the client is not following the program requirements or cooperating with program objectives including, but not limited to, a failure to provide information to program representatives (441 IAC 177.11(7))
- A *Notice of Decision/Notice of Action* from income maintenance is issued that the client is no longer financially eligible.

The following sections give more information on:

- When the client is absent from home for more than 15 days
- Termination procedures
- Appeals

Client Absent From Home for More Than 15 Days

Allow the client to remain eligible and make payment for services for no more than 15 days in any calendar month when the client is absent from home for a temporary period. Do not authorize payment for over 15 days of continuous absence, whether or not the absence extends into a succeeding month or months.

When it is known that the out-of-home stay will exceed 15 days, tell the IM worker to send a termination notice to the client. Notify the IHHRC care provider and supervising practitioner (if applicable).

Termination Procedures

To terminate IHHRC services, use the following procedures:

1. Notify the client of the termination on form 470-0602, *Notice of Decision: Services*, allowing timely and adequate notice except as described in 1-E, *Dispensing With Timely Notice*. **Always** send a copy to the IM worker so they can end the program request in IoWANS.

   EXCEPTION: When the IM worker has terminated IHHRC benefits due to the client no longer being financially eligible, **do not** send a *Notice of Decision*. The IM worker will send the service worker a copy of the IM Notice of Decision. That notice will serve as the notice of termination. Keep the notice of termination in the HHS service case file.

2. Notify the IHHRC care provider and supervising practitioner (if applicable) of the termination of service.

3. Continue payment during the ten-day notice period if service is provided during that time. For situations not requiring timely notice, payment shall be stopped immediately upon the date of the termination notice.

Appeals

Legal reference: 441 IAC 7.6(217)

Advise each applicant and recipient of the right to appeal any adverse action affecting the person's status. Assist in the filing process as needed.

If an appeal is received, immediately complete Part II of form 470-0487, *Appeal and Request for Hearing*. Send the written appeal, and a copy of the notice that the client is appealing to the Appeals Section within one day of receiving the appeal request.

Forward a summary and supporting documentation to the Appeals Section within 10 days of receiving the appeal request. Send a copy to the client and the client's representative, if any.

Follow the appeal processes outlined in 1-E, *Appeals and Hearing*.