

Home- and Community-Based Services (HCBS) Attendant Care (AC) and Self-Directed Personal Care Agreement

This is an agreement between a member of services under a Medicaid HCBS waiver and a person providing either AC or SDPC. AC will be used to represent service requirements for both AC and SDPC throughout the remainder of the agreement.

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|-----------------|------------------------------|----------------|
| Name of Member: | Effective date of agreement: | Agency or CCO: |
|-----------------|------------------------------|----------------|

The Iowa Medicaid program will reimburse for AC services provided under this agreement when AC is part of the member's person-centered service plan, and the case manager or community-based case manager has determined that the prior training and experience of the AC provider are sufficient to meet the member's needs noted in this agreement. The member agrees not to hold the case manager or community-based case manager responsible for any problems resulting from any deficiency in the provider's training or experience. The AC provider must report any health, safety, or welfare concerns to the case manager within 24 hours of the occurrence.

Instructions

The member or the member's legal representative must complete this form by entering information describing how the AC provider will meet the standards and responsibilities and the agreed-upon rate of payment. **Before the AC provider begins providing the AC service and receives payment, all the following must occur:**

1. The member and/or the member's legal representative, and the AC provider will decide which services are needed, the number of units to be provided, and the rate of payment to the AC provider.
2. This AC agreement must be filled out completely and signed by both the member or member's legal representative, case manager or community-based case manager and the AC provider to show they approve all the information in the agreement and shall abide by all requirements in the agreement.
3. The original electronic copy of the AC agreement is kept by the case manager or community-based case manager and attached to the person-centered plan. A copy of the AC agreement must be given to and maintained by the member, the member's legal representative if applicable, the AC provider, and to the nurse or therapist supervising the provision of skilled services, if any.
4. The service worker/case manager shall distribute a Notice of Decision to the member, the member's legal representative if applicable, and the AC provider showing that the case manager or community-based case manager has approved the AC services, the AC provider, the number of approved units, and the rate of payment.

5. The AC provider must provide only the AC services as described in the AC agreement and approved in the case manager or community-based case manager's comprehensive person-centered service plan. The AC provider must document the AC activities performed as required by 441 Iowa Administrative Code 79.3(249A). Form 470-4389 is available for recording AC activities. Electronic Visit Verification (EVV) is also a required component of AC and must be used. The record must show that the service is necessary due to the member's assessed needs as shown by Level of Care Assessment, needs or goals as reflected in the person-centered service plan. The record must state the AC provider's specific actions or activities and the member's response to the services rendered, including any observed changes in the member's physical or mental health, mood, or behavior.
6. The AC provider cannot disclose protected health information (PHI). The HIPAA Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. "Individually identifiable health information" is information, including demographic data, that relates to:
 - The individual's past, present or future physical or mental health or condition,
 - The provision of health care to the individual, or
 - The past, present, or future payment for the provision of health care to the individual, and
 - That identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.
7. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number). Civil and criminal penalties may be imposed for failure to comply with the Privacy Rule. Civil penalties of \$100 per incident, not to exceed \$25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year. Criminal penalties with fines of \$50,000 and up to one-year imprisonment can be imposed for an individual who knowingly obtains or discloses individually identifiable health information. The criminal penalties increase to \$100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to \$250,000 and up to 10 years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm.

Agreement:

The member and the AC provider agree that:

1. The AC provider, as an agency or through CCO, is not an agent, employee, or servant of the state of Iowa, the Department of Health and Human Services (HHS), or any of its employees. It is the AC provider agency responsibility to determine employment status in regard to income tax and social security. Providers of AC service have no recourse to HHS to collect payments performed outside of the provisions of this agreement. They are not an employee of the MCO.
2. This agreement will be reviewed annually and when there are significant changes in the member's condition or situation.

This agreement **must** be amended and approved by the case manager or community-based case manager whenever there is a change:

- a) of a AC provider,
- b) in the service components to be provided,
- c) in the description of provider activity,
- d) in the rate of payment,
- e) in the number of approved units approved to be provided,
- f) of the tasks and scope of service to be provided.

3. When required, the AC provider will utilize Electronic Visit Verification

Describe the service activities provided by the AC provider. Enter the amount of time per day and the number of days per week or month required to provide the activity. Enter "Not applicable" (NA) for components of the AC service that will not be provided.

*Reminders, cueing, and supervision are not billable AC services. For tasks that benefit a multi-person household (housekeeping, meal prep, laundry, etc.), consideration must be taken to only include the portion of the task that the member would benefit from.

| Non-Skilled Service Components. To be completed by the member or member's legal representative. | Describe AC Provider Activity as allowable by the Iowa Administrative Code. | List the amount of time required each day for each activity. | Number of days service will be provided per month. | Total minutes for the line. |
|--|--|---|---|--|
| N1 Dressing | | | | |

Describe the service activities provided by the AC provider. Enter the amount of time per day and the number of days per week or month required to provide the activity. Enter "Not applicable" (NA) for components of the AC service that will not be provided.

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|--|---|--|---|---|--|
| N2 | Bathing, grooming, personal hygiene – includes transfer in/out of bath/shower, shaving, hair care, make-up, and oral hygiene. | | | | |
| N3 | Meal preparation and feeding – includes cooking, eating, and feeding assistance (but not the cost of meals themselves). | | | | |
| N4 | Toileting – includes bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter), and transferring on/off toilet. | | | | |
| N5 | Transferring, ambulation, mobility – includes access to and from bed or a wheelchair, repositioning, and mobility in general. | | | | |

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|--|--|--|---|---|--|
| N6 | Essential housekeeping – activities which are necessary for the health and welfare of the member general cleaning. | | | | |
| N7 | Essential housekeeping activities which are necessary for the health and welfare of the member: Grocery Shopping | | | | |
| N8 | Essential housekeeping activities which are necessary for the health and welfare of the member: Laundry | | | | |
| N9 | Minor wound care – includes foot care, skin care, and skin/nail observation and inspection. Potential "soaking time" is not a billable service. | | | | |

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|--|--|--|---|---|--|
| N10 | Financial and scheduling assistance – includes money management, cognitive tasks, and scheduling personal business matters (if a member has a payee for money management this section can not be used for bill paying). | | | | |
| N11 | Assistance in the workplace – assistance with self-care tasks, environmental tasks, and medical supports necessary for the member to perform a job. Assistance with understanding and completing essential job functions is not included. | | | | |

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|--|---|---|---|------------------------------------|
| | Describe AC Provider Activity as allowable by the Iowa Administrative Code. | List the amount of time required each day for each activity. | Number of days service will be provided per month. | Total minutes for the line. |
| N12 | Communication – includes interpreting, reading services, assistance with communication devices, and supports that address the member's unique communication needs. This does not include reading mail, newspapers or helping the member 'talk' to friends. This does not include communication between staff and member. | | | |
| N13 | Essential transportation – assisting or accompanying the member in using transportation essential to the health and welfare of the member and to reduce social isolation. | | | |

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|--|--|--|---|---|------------------------------------|
| N14 | Medication assistance – includes assisting the member in sorting, storing, organizing, and taking medications ordinarily self-administered. It also includes medication equipment maintenance and medication administration. | | | | |

| Skilled Service Components. To be completed by the member or member's legal representative. Supervision of skilled services. Skilled Attendant Care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. | | Describe AC Provider Activity as allowable by the Iowa Administrative Code. | List the amount of time required each day for each activity. | Number of days service will be provided per month. | Total minutes for the line. |
|--|---|--|---|---|------------------------------------|
| S1 | Tube feedings if a member is unable to eat solid foods. | | | | |
| S2 | Assistance with intravenous therapy administered by a licensed nurse. | | | | |

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|--|---|--|---|---|------------------------------------|
| S3 | Parenteral injections required more than once a week. | | | | |
| S4 | Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required. | | | | |
| S5 | Respiratory care, including inhalation therapy, tracheotomy care, and ventilator. | | | | |
| S6 | Care of decubiti and other ulcerated areas, noting and reporting the nurse or therapist. | | | | |

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|--|--|--|---|---|------------------------------------|
| S7 | Rehabilitation services. Rehabilitation services include bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, re-teaching the activities of daily living, respiratory and breathing programs, reality orientation, reminiscing therapy, re-motivation, and behavior modification. | | | | |
| S8 | Colostomy care. | | | | |
| S9 | Care of medical conditions out of control (includes brittle diabetes and comfort care of terminal conditions) when hospice is not utilized. | | | | |
| S10 | Post-surgical nurse delegated activities under the supervision of the licensed nurse. | | | | |

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|--|---|--|---|---|------------------------------------|
| S11 | Monitoring medication requiring close supervision because of a fluctuating physical or psychological condition. | | | | |
| S12 | Preparing and monitoring responses to therapeutic diets. | | | | |
| S13 | Recording and reporting of changes in vital signs to the nurse or therapist. | | | | |
| | | | | Total Minutes | |

Enter the number in the "Total Units" box into the Total Units Per Month box below:

The member/member's legal representative, the AC provider, and the case manager or community-based case manager determine the AC provider's rate of pay. The payment of AC services must not exceed the fee limits allowed in the AC program or without a signed copy of the approved Waiver of Administrative Rule. The rate of service multiplied by the number of approved units of AC services per month cannot exceed the member's total monthly budget allowed in the member's person-centered plan. Complete the waiver type and agreed upon reimbursement rate to the provider as follows:

Waiver type (check one):

| | | | | | |
|-----------------------------------|--|---------------------------------------|--|----------------------------------|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Health and Disability | <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Elderly | <input type="checkbox"/> Physical Disability |
|-----------------------------------|--|---------------------------------------|--|----------------------------------|--|

| HCPS Code | Provider Type | Fee Per Unit | Maximum Units |
|-----------|------------------------------|----------------|---------------|
| S5125 | Agency AC provider | \$ per 15 min. | |
| S5125 U3 | Agency AC provider – skilled | \$ per 15 min. | |
| T1019 | CCO SDPC provider | \$ per 15 min. | |
| T1019 U3 | CCO SDPC provider - skilled | \$ per 15 min. | |

I agree to abide by all the requirements in this AC agreement including the following:

- That my criminal and abuse records will be checked for reported or confirmed criminal history or abuse and to keep the Department informed of changes to criminal and abuse records.
- To hold HHS harmless against all claims, damages, losses, costs, and expenses, including attorney fees, arising out of the performance of this AC agreement by any and all persons.
- To keep both fiscal and designated clinical/medical documentation records of all AC services provided which are charged to the medical assistance program and to maintain these AC records during the time the member is receiving services from the provider and for at least five years from the date of the last claims submission. Documentation shall include the following information for each unit of AC service provided and billed:
 1. Full name of the member receiving the AC service as it appears on their medical assistance card.
 2. Member's date of birth.
 3. Medical assistance identification number.

4. Full name of the person providing the service. If the provider functions under a professional license or is certified to perform certain tasks, list the title after the provider's name. If the provider does not have a title, enter "AC Worker."
5. Agency name (if applicable).
6. Specific date of the AC service provided including the day, month, and year.
7. Total units billed for the date of service.
8. Waiver type and service procedure code as identified in this agreement.
9. Location in which the service was provided including address.
10. Description of the AC service provided as described in this agreement and as authorized in the case manager or community-based case manager's person-centered service plan.
11. Description of the provider's interventions and supports provided and the member's response to those interventions and supports.
12. Identification of any health, safety, and welfare concerns.

I hereby confirm that all information provided by me on this form is true and correct to the best of my knowledge.

| | |
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| AC or Self-Directed Personal Care Provider Signature | Date |
| Member Signature | Date |
| Case Manager or Community-based Case Manager Signature | Date |

Additional Information on Billing:

Submit all claims for all AC on form [**470-2486, Claim for Targeted Medical Care**](#). AC services must be billed in whole units and both the member and provider must sign and date the claim. Claims should be submitted monthly following the month that services were provided. Iowa Medicaid (IM) has 30 days to process a claim. If a submitted claim contains errors, payment to the provider may be delayed. Questions regarding the form or to order blank forms, contact HHS Provider Services at **1-800-338-7909** or locally (in the Des Moines area) at 515-256-4609. The downloadable version as well as instructions for completing the form is available on the HHS website at <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/claims-and-billing>

Fee-for-Service (FFS) members:

Claims Billing Address: Iowa Medicaid Enterprise, PO Box 150001, Des Moines, IA 50315

HHS website: <http://hhs.iowa.gov/>

IM Provider Services: **1-800-338-7909** or imeproviderservices@hhs.iowa.gov.

Wellpoint members:

Claims Billing Address: Wellpoint, PO Box 61010, Virginia Beach, VA 23466

Provider Portal/Website: <https://www.provider.wellpoint.com/iowa-provider/home>

Provider Services: **1-800-454-3730**

Iowa Total Care members:

Claims Billing Address: Iowa Total Care, Attn: Claims Dept., PO Box 8030, Farmington, MO 63640

Provider Portal/website: <https://www.iowatotalcare.com/providers.html>

Provider Services: **1-833-404-1061**

Molina Healthcare of Iowa

All claims must be submitted electronically.

Electronic Billing Options

AC and Self-Directed Personal Care providers are encouraged to bill electronically. IM offers the following options for providers to consider for electronic billing:

- ABILITY PC-ACE Pro: This software is available to all providers through the IM for billing FFS claims. Contact IME Provider Services at the number above for additional information. There is no cost for FFS member claims billed through ABILITY PCACE Pro.
- Managed Care Organization (MCO) portals: Each MCO has an online portal for claim submission and management. Contact the MCOs at the numbers listed above for additional information.
- Claims can be submitted electronically through the designated EVV vendor (<https://hhs.iowa.gov/medicaid/about-medicaid/medicaid-projects/evv>), which submits claims weekly. Wellpoint requires all claims to be submitted electronically.