

**Home- and Community-Based Services
Brain Injury Waiver
Information Packet**

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

In addition to home and community-based waiver services, the Brain Injury Waiver enrolled members have access to Medicaid covered services and benefits. Medicaid covers a broad array of health services, in addition to the services provided by the waiver, limits out-of-pocket costs. These include, but not limited to, primary care, behavioral health services, skilled nursing care, dental, vision, and emergency care. Most of Iowa's Medicaid members are served by the managed care program called IA Health Link. Managed care organizations coordinate your care.

If you need assistance, please contact Iowa Medicaid Member Services at **1-800-338-8366** or locally in the Des Moines area at **515-256-4606**, Monday through Friday, from 8 a.m. until 5 p.m.

*For telephone accessibility assistance if you are deaf, hard-of-hearing, deaf-blind, or have difficulty speaking, call Relay Iowa TTY at **1-800-735-2942**.*

General Parameters

- ◆ Brain Injury (BI) waiver services are individualized to meet the needs of each member. The following services are available:
 - Adult Day Care
 - Behavioral Programming
 - Career Exploration
 - Case Management
 - Consumer-Directed Attendant Care
 - Family Counseling and Training
 - Home and Vehicle Modifications
 - Interim Medical Monitoring and Treatment
 - Personal Emergency Response System
 - Prevocational Services
 - Respite
 - Specialized Medical Equipment
 - Supported Community Living
 - Supported Employment
 - Transportation
 - Consumer Choices Option
- ◆ All HCBS waiver services must be provided in integrated community-based settings.
- ◆ The services, which are considered necessary and appropriate to meet the member's needs, will be determined through an interdisciplinary team (IDT) consisting of the member, case manager or DHS service worker, service providers, and other persons the member chooses.
- ◆ All members will have a comprehensive service plan developed by a case manager or DHS service worker in cooperation with the member. A case manager or community-based case manager prior to implementation of services must sign and date the comprehensive service plan. The member must receive case management services.
- ◆ This comprehensive service plan must be completed before the implementation of services. The comprehensive service plan for members **aged 20 or under** must be developed or reviewed taking into consideration those services that may be provided through the individual education plan (IEP) and Early Periodic Screening, Diagnosis and Treatment (EPSDT or Care for Kids) plans.
- ◆ Members shall access all other services for which they are eligible and that are appropriate to meet their needs as a precondition of eligibility for the BI waiver.
- ◆ The member must choose HCBS services as an alternative to institutional services.
- ◆ In order to receive BI waiver services, an approved BI waiver service provider must be available to provide those services. All BI waiver service providers must have training regarding or experience with persons who have a brain injury.
- ◆ Medicaid waiver services cannot be simultaneously reimbursed with another Medicaid waiver service or Medicaid service.
- ◆ BI waiver services cannot be provided when a member is an inpatient in a medical institution.

- ◆ Members must need and use at least one unit of the case management service during each quarter of the calendar. In addition, the members must need and use at least one unit of another BI waiver service during each quarter of the calendar year.
- ◆ Following is the hierarchy for accessing waiver services:
 1. Private insurance
 2. Medicare
 3. Medicaid/ and EPSDT (Care for Kids)
 4. BI waiver services
 5. In Home Health Related Care (IHHRC)
- ◆ A designated number of members (payment slots) can be served under the HCBS BI program.
- ◆ In addition to BI Waiver services, assistance may be available through the In-Home Health-Related Care (IHHRC) program or the Rent Subsidy program through the Iowa Finance Authority. Members may contact the Iowa Finance Authority.

Member Eligibility Criteria

Members may be eligible for HCBS BI waiver services by meeting the following criteria:

- ◆ Be an Iowa resident and a United States citizen or a person of foreign birth with legal entry into the United States.
- ◆ Be determined to have a brain injury diagnosis included in a definitive list identified in 441 Iowa Administrative Code 83.81(249A). The Iowa Medicaid Enterprise, Medical Services Unit will confirm the brain injury diagnosis.
- ◆ Be determined eligible for Medicaid (Title XIX). Members may be Medicaid-eligible before 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 member has previously been determined ineligible.
- ◆ Be at least one month old.
- ◆ Be determined by the Iowa Medicaid Enterprise, Medical Services Unit, to need a level of care that includes one of the following:
 - Intermediate care facility for the intellectually disabled (ICF/ID)
 - Nursing facility (NF)
 - Skilled nursing facility (SNF)

Service Descriptions

Please note:

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

Adult Day Care

- What:** Adult day care is an organized program of supportive care in a group environment. The care is provided to members who need a degree of supervision and assistance on a regular or intermittent basis in a day care center.
- Where:** In an adult day program
- Unit:** A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

Behavioral Programing

- What:** Individually designed strategies to increase the member's appropriate behaviors and decrease any maladaptive behaviors that interfere with the member's ability to remain in the community. This may include, but is not limited to, the following:
- ◆ Clinical redirection,
 - ◆ Token economies,
 - ◆ Reinforcement,
 - ◆ Extinction,
 - ◆ Modeling, and
 - ◆ Overlearning.
- Where:** In the member's home or community, based on the member's need for intervention. Not in the provider's home.
- Unit:** A unit of service is 15 minutes

Career Exploration Services

- What:** Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially-based, informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include:
- ◆ Business tours,
 - ◆ Attending industry education events,
 - ◆ Benefit information,
 - ◆ Financial literacy classes, and
 - ◆ Attending career fairs.
- Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include, but is not limited to the following activities:

- ◆ Meeting with the member and the member’s family, guardian or legal representative to introduce them to supported employment and explore the member’s employment goals and experiences,
- ◆ Business tours,
- ◆ Informational interviews,
- ◆ Job shadows,
- ◆ Benefits education and financial literacy,
- ◆ Assistive technology assessment, and
- ◆ Job exploration events.

Where: Prevocational career exploration services shall take place in community-based nonresidential settings.

Unit: A unit of service is one hour

Case Management Services

What: The goal of case management is to enhance the member’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 member’s home and community. Not in the provider’s home.

Unit: A unit of service is 15 minutes.

Consumer-Directed Attendant Care (CDAC)

What: Assistance to the member with self-care tasks, which the member would typically do independently if the member was otherwise able. An individual or agency, depending on the member’s needs, may provide the service. The member, parent or guardian shall be responsible for selecting the individual or agency that will provide the components of the CDAC services to be provided.

The CDAC service may include assistance with non-skilled and skilled services. The skilled services must be completed 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,
- ◆ Catheterizations,
- ◆ Respiratory care,
- ◆ Care of decubiti and other ulcerated areas,
- ◆ Rehabilitation services,
- ◆ Colostomy care,
- ◆ Care of out of control medical conditions,
- ◆ 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.

Employment support includes assistance needed to go to or return from the place of employment and assistance with job-related tasks while the member is on the job site.

A determination must be made regarding what services will benefit and assist the member. Those services will be recorded in the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372. This *Agreement* becomes part of the comprehensive service plan developed for the member.

This service is only appropriate if the member, parent, guardian, or attorney-in-fact under a durable power of attorney for health care has the ability to and is willing to manage all aspects of the service.

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

Does not include: The following items are not included:

- ◆ Day care
- ◆ Babysitting
- ◆ Respite

- ◆ Room and board
- ◆ Parenting
- ◆ Case management
- ◆ Cost of transportation
- ◆ Assistance with understanding or performing essential job functions

CDAC cannot replace a less expensive service.

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

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

The cost of nurse supervision, if needed.

Unit: A unit of service is 15 minutes

Maximum units: The Medicaid case manager or DHS service worker, working with the member and the interdisciplinary team, establishes a dollar amount that may be used for CDAC. The amount is then entered into the comprehensive service plan along with information about other HCBS services the member may receive. This monetary information is also entered into the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372, along with the responsibilities of the member and the provider and the activities for which the provider will be reimbursed.

The member and the provider come to an agreement on an hourly or daily billing unit and the cost per unit. The case manager submits the request for CDAC through the Individual Services Information System (IoWANS) along with the *Certificate for Medical Necessity* and CDAC agreement when applicable. A completed copy of the agreement is distributed to the member, the provider, and the case manager or DHS service worker. The agreement becomes part of the comprehensive service plan. These steps must be completed **before** service provision.

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

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

Provider enroll: The provider must be enrolled with the Department's fiscal agent and certified as a CDAC provider **before** the completion of the *HCBS Consumer-Directed Attendant Care Agreement*.

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

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

Family Counseling and Training

What: Face-to-face mental health services that help the member, the member's family members or friends with:

- ◆ Crisis coping strategies,
- ◆ Stress reduction,
- ◆ Management of depression,
- ◆ Alleviation of psychosocial isolation, and
- ◆ Support in coping with the effects of brain injury.

Where: The member's home, community, community mental health center, or other location used by a mental health provider that meets Mental Health and Disabilities Commission accreditation. Not in the provider's home.

Unit: A unit of service is 15 minutes

Home and Vehicle Modification (HVM)

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

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

- ◆ Kitchen counters, sink space, and cabinets
- ◆ Special adaptations to refrigerators, stoves, and ovens
- ◆ Bathtubs, bath chairs and toilets to accommodate transfer, special handles and hoses for showerheads, water faucet controls, and accessible shower and sink areas
- ◆ Grab bars and handrails
- ◆ Turnaround space adaptations
- ◆ Ramps, lifts, and door, hall, and window widening
- ◆ Fire safety alarm equipment specific for disability
- ◆ Voice activated, sound activated, light activated, motion activated, and electronic devices directly related to the member's disability

- ◆ Vehicle lifts, driver specific adaptations, remote start systems, including such modifications already installed in a vehicle
- ◆ Keyless entry systems
- ◆ Automatic opening device for home or vehicle door
- ◆ Special door and window locks
- ◆ Specialized doorknobs and handles
- ◆ Plexiglas replacement for glass windows
- ◆ Modification of existing stairs to widen, lower, raise or enclose open stairs
- ◆ Motion detectors
- ◆ Low pile carpeting or slip resistant flooring
- ◆ Telecommunications device for people who are deaf
- ◆ Exterior hard surface pathway
- ◆ New door opening
- ◆ Pocket doors
- ◆ Installation or relocation of controls, outlets, and switches
- ◆ Air conditioning and air filtering if medically necessary
- ◆ Heightening of existing garage door opening to accommodate modified van

Does not include:

The following items are not included:

- ◆ Modifications that increase the square footage of the home
- ◆ Items for replacement that are the responsibility of the homeowner or landlord
- ◆ Vehicle purchase
- ◆ Fences
- ◆ Furnaces
- ◆ Any modifications or adaptations available through regular Medicaid
- ◆ Purchasing, leasing or repairs of a motorized vehicle

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

Maximum: The member is eligible for up to \$6592.66 per year.

Interim Medical Monitoring and Treatment (IMMT)

What: Monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting for persons age 20 and under. Interim medical monitoring and treatment (IMMT) services shall provide experiences for each member's social, emotional, intellectual, and physical development. The service will include comprehensive developmental care and any special services for a member with special needs. It will also include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

The service allows the member's usual caregivers to be employed. IMMT may also be used after the death of a usual caregiver. IMMT services may include supervision for the child during transportation to and from school when not available through school or

other sources. IMMT services may also be provided for a limited period of time when the usual caregiver is involved in the following circumstances:

- ◆ Attendance at academic or vocational training
- ◆ Employment search
- ◆ Hospitalization
- ◆ Treatment for physical or mental illness

Note: To be eligible for this service the child must first be accessing intermittent services, private duty nursing or home health aide through EPSDT.

Where: Services may be provided in:

- ◆ The home,
- ◆ A registered group child care home,
- ◆ A registered family child care home,
- ◆ A licensed child care center, or
- ◆ During transportation to and from school.

Providers of this service:

- ◆ Must be at least 18 years of age.
- ◆ Cannot be the spouse of the member.
- ◆ Cannot be the parent or stepparent of a member age 17 or under.
- ◆ Cannot be the usual caregiver.
- ◆ Must be qualified by training or experience as determined by the usual caregiver.

A licensed medical professional on the member's interdisciplinary team must be able to provide medical intervention or intervention in a medical emergency.

Does not include: May not duplicate any regular Medicaid or waiver services provided under the state plan.

Do not use this service to replace day care for a child who does not need medical monitoring and treatment.

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

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

Services not covered by EPSDT include the following:

- ◆ Services to children with Medicaid HMO coverage
- ◆ Mental health services to children enrolled in the Iowa Plan

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

Unit:

Maximum units: 12 one-hour units of service per day

Personal Emergency Response System (PERS) or Portable Locator System

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

A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

Where: The PERS or portable locator is connected to the member's and includes an electronic device used by the member.

Unit: A unit is one time installation fee *and/or* one month of service.

Maximum Twelve months of service per state fiscal year (July 1 – June 30).

Prevocational Services

What: Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include, but are not limited to:

- ◆ The ability to communicate effectively with supervisors, coworkers, and customers;
- ◆ An understanding of generally accepted community workplace conduct and dress;
- ◆ The ability to follow directions;
- ◆ The ability to attend to tasks, workplace problem-solving skills, and strategies;
- ◆ General workplace safety and mobility training;
- ◆ The ability to navigate local transportation options;
- ◆ Financial literacy skills, and
- ◆ Skills related to obtaining employment.

Where: Prevocational services shall take place in community-based nonresidential settings.

Unit: A unit of service is 15 minutes

Does not Assisting a member in learning tasks or skills for a specific job.

include:

Prevocational services payment shall not be made for the following:

- ◆ Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.
- ◆ Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- ◆ Compensation to members for participating in prevocational services.
- ◆ Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.
- ◆ The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.
- ◆ A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

Respite

What:

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

- ◆ **Specialized respite** means respite provided at a ratio of one or more staff to one member 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 at a ratio of one staff to two or more members.
- ◆ **Basic individual respite** means respite provided at a ratio of one staff to one member for individuals who do not have specialized medical needs that would require care by a licensed registered nurse or licensed practical nurse.

Where:

Respite may be provided in:

- ◆ The member's home,
- ◆ Another family's home,
- ◆ Camps,
- ◆ Organized community programs (YMCA, recreation centers, senior citizens' centers, etc.),
- ◆ ICF/ID,
- ◆ RCF/ID,

- ◆ Hospital,
- ◆ Nursing facility,
- ◆ Skilled nursing facility,
- ◆ Assisted living program,
- ◆ Adult day care center,
- ◆ Foster group care,
- ◆ Foster family home, or
- ◆ DHS licensed daycare.

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

Unit: A unit of service is 15 minutes

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** be provided to members residing in the family, guardian, or usual caregiver's home during the hours that 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.

Specialized Medical Equipment

What: Specialized medical equipment is medically necessary equipment as determined by a medical professional (i.e., physical therapist, occupational therapist, nurse, licensed psychologist, speech therapist). It is designed for the personal use by the member and provides for the safety and health of the individual. Specialized medical equipment is not normally funded by Medicaid, the educational system or vocational rehabilitation programs and is not provided by voluntary means. This includes, but is not limited to the following:

- ◆ Electronic aids and organizers,
- ◆ Medicine-dispensing devices,
- ◆ Communication devices,
- ◆ Bath aids, and
- ◆ Non-covered environmental control units.

This service can include the repair and maintenance costs of the specialized medical equipment purchased.

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

Unit: A unit is the cost of the item.

Maximum: The annual maximum is \$6592.66.

Supported Community Living (SCL)

What: SCL provides 1 to 24 hours of support per day based on the individual's needs.

This service is designed to assist the member with daily living needs. Assistance may include, but is not limited to:

- ◆ Personal and home skills,
- ◆ Community skills,
- ◆ Personal needs,
- ◆ Transportation, and
- ◆ Treatment services.

Where: Members can receive SCL in the family home, the guardian's home or other typical community settings (i.e., houses, apartments, condominiums, townhouses, trailers, etc.). Not in the provider's home.

All living arrangements must be integrated into the community.

The typical and preferred living unit may include one to four persons.

Does not include: The following items are not included:

- ◆ Transportation to and from work or a day program
- ◆ Room and board costs
- ◆ Academics
- ◆ Medical services
- ◆ Vocational services
- ◆ Daycare and babysitting
- ◆ Parenting
- ◆ Case management

Unit: A unit is 15 minutes **or** one day.

A daily rate applies to members who live outside of their family, legal representative or foster family home and for whom a provider has primary responsibility for supervision or structure during the month.

A daily rate applies to members who live outside of the family home and receives on-site staff supervision for 8 or more hours during a 24-hour day.

Supported Employment (SE)

What: Individualized services provide supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job:

- ◆ In competitive or customized employment or self-employment,
- ◆ In an integrated work setting in the general workforce, and
- ◆ At or above the state's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

The three components of this service are:

- ◆ **Individual supported employment.** These are services provided to obtain competitive employment. Any of the following activities may be included:
 - Benefits education
 - Career exploration
 - Employment assessment
 - Assistive technology assessment
 - Trial work experience
 - Person-centered employment planning
 - Development of visual and traditional résumés
 - Job-seeking skills training and support
 - Outreach to prospective employers on behalf of the member
 - Job analysis
 - Identifying and arranging transportation
 - Career advancement services
 - Reemployment services (if necessary)
 - Financial literacy and asset development
 - Other employment support services deemed necessary
 - Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization
 - Engagement of natural supports during initial period of employment
 - Assistive technology solutions during initial period of employment
 - Transportation of the member during service hours
 - Initial on-the-job training to stabilization
- ◆ **Long term job coaching.** These are services provided to maintain competitive employment. Any of the following activities may be included:
 - Job analysis
 - Job training and systematic instruction
 - Training and support for use of assistive technology and adaptive aids.
 - Engagement of natural supports.
 - Transportation coordination.

- Job retention training and support.
- Benefits education and ongoing support.
- Supports for career advancement.
- Financial literacy and asset development.
- Employer consultation and support.
- Negotiation with employer on behalf of the member (e.g., accommodations, employment conditions, access to natural supports, and wage and benefits).
- Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
- Transportation of the member during service hours.
- Career exploration services leading to increased hours or career advancement

Tier 1 1 contact per month
 Tier 2 2 – 8 hours per month
 Tier 3 9 – 16 hours per month
 Tier 4 17 – 25 hours per month
 Tier 5 26 or more hours per month

◆ **Small group employment.** A team of no more than eight individuals with disabilities in a teamwork setting receiving supports to maintain employment.

- Employment assessment.
- Person-centered employment planning.
- Job placement (limited to service necessary to facilitate hire into individual employment, paid at minimum wage or higher, for a member in small group-supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
- Job analysis.
- On-the-job training and systematic instruction.
- Job coaching.
- Transportation planning and training.
- Benefits education.
- Career exploration services leading to career advancement outcomes.
- Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.
- Transportation of the member during service hours.

Tier 1 Groups of 2 to 4
 Tier 2 Groups of 5 or 6
 Tier 3 Groups of 7 or 8

Where: Job placements shall be made in integrated settings with the majority of co-workers being persons without disabilities. Not to be provided in the provider's home or office.

For whom: Members age 16 or older.

Does not include: Not included are:

- ◆ Members who are eligible for similar services from the Division of Vocational Rehabilitation Services
- ◆ Members who are eligible for similar services from educational services
- ◆ Services involved in placing or maintaining members in day activity, work activity or sheltered workshop programs
- ◆ Supports for volunteer work or unpaid internships
- ◆ Tuition for educational or vocational training

Transportation

What: Transportation services may be provided for members to:

- ◆ Conduct business errands,
- ◆ Complete essential shopping,
- ◆ Receive medical services not reimbursed through non-emergency medical transportation(NEMT),
- ◆ Travel to and from work or day programs, and
- ◆ Reduce social isolation

Where: In the community as identified in the comprehensive service plan.

Does not include: Transportation simultaneously reimbursed with transportation costs, which may be included in an SCL rate, or medical transportation that is reimbursable through non-emergency medical transportation (NEMT) funding

Unit: Per trip **or** per mile

Consumer Choices Option (CCO)

What: The **Consumer Choices Option (CCO)** is an option that is available under most HCBS waivers. This option will give you more control over a targeted amount of Medicaid dollars. You will use these dollars to develop an individual budget plan to meet your needs by directly hiring employees and purchasing other goods and services.

CCO offers more choice, control, and flexibility over your services, as well as, more responsibility. Additional assistance is available if you choose this option. You will choose an Independent Support Broker who will help you develop your individual budget and help you recruit employees.

You will also work with a financial management service that will manage your budget for you and pay your workers on your behalf. Contact your case manager, DHS service worker, or service worker for more information. Additional information may also be found at the website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/consumer-choices-option>.

Services that may be included in the individual budget under CCO are:

- ◆ Consumer-directed attendant care
- ◆ Home and vehicle modification
- ◆ Prevocational services
- ◆ Basic individual respite
- ◆ Specialized medical equipment
- ◆ Supported community living
- ◆ Supported employment
- ◆ Transportation

Where: In the member's home or community. Not in the provider's home or office.

Does not include: CCO cannot be used to pay for:

- ◆ Room and board,
- ◆ Workshop services,
- ◆ Other childcare, and
- ◆ Personal entertainment items.

Goods and services provided through CCO cannot otherwise be provided through Medicaid state plan services. Goods and services would:

- ◆ Decrease the need for other Medicaid services,
- ◆ Promote inclusion in the community, or
- ◆ Increase your safety in your home and community.

Unit: A monthly budget amount is set for each member.

Application Process

The application process for the BI waiver requires a coordinated effort between the Department of Human Services (DHS) and non-department agencies on behalf of the prospective member. If you are currently working with DHS personnel, please contact that person regarding the application process.

Please respond immediately to correspondence from an income maintenance (IM) worker or Medicaid case manager or community-based case manager. 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 BI waiver is made with an IM worker at the local DHS office. The IM worker will secure a payment slot or put the member's name on a waiting list.

Upon availability of a payment slot, the IM worker will process the application and refer the member to a Medicaid case manager or DHS service worker (MCM).

For adults applying for the BI waiver, an appointment will be scheduled with the IM worker. For children applying for this waiver, telephone contact will be made to the family home.

Documentation necessary for this application may include the following:

- ◆ Medical records that indicate a brain injury diagnosis
- ◆ 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.

Assessment tools, the interRAI and Mayo Portland Adaptability Inventory IV are completed by the Medicaid Core Standardized Assessment Contractor or the Managed Care Organization (MCO).

2. The Iowa Medicaid Enterprise, Medical Services unit will review the assessment tools to determine if member needs require Intermediate Care Facility for Persons with an Intellectual Disability (ICF/ID), skilled nursing or ICF (nursing) level of care.

If the member does not meet level of care, the IM worker will send a *Notice of Decision (NOD)* notifying the member of the denial. The member has the right to appeal the decision. The appeal process is explained on the *NOD*.

3. The assessments must be completed annually. If the member is enrolled with an MCO, the MCO will make the annual level of care determination after the assessments are completed. If the member is FFS, IME will make the annual level of care determination after the assessments are completed. Iowa Medicaid retains the final determination authority for all level of care determinations.
4. An interdisciplinary team meeting is conducted to determine the services that are needed, the amount of service to be provided, and the providers of the services. The interdisciplinary team meeting will be attended by the member, member's family, the case manager, community-based case manager, BI waiver service providers, and may also include other professional or support persons. The end result of the interdisciplinary team decisions will be a comprehensive service plan developed, signed, and dated by the case manager or community based case manager.

5. For MCO enrolled members, the MCO must approve the comprehensive service plan and authorize services.
6. For Fee-for-Service members (FFS) the Individualized Services Information System (IoWANS) process must be completed with the culmination of an approved comprehensive service plan before the implementation of services. An approved comprehensive service plan recorded in the IoWANS system authorizes payment for waiver services for FFS members.
7. The Medicaid case manager or MCO will issue a *Notice of Decision* if the member is approved to receive BI waiver services.

Estate Recovery

Estate recovery legal reference: 441 IAC 75.28(7)

Estate recovery applies to all persons who have received Medicaid on or after July 1, 1994, and are age 55 or older, or who live in a medical facility and cannot reasonably be expected to return home. This includes members on waiver programs such as the Elderly Waiver Program and Medically Needy Program.

When a Medicaid member dies, assets from their estate are used to reimburse the state for costs paid for medical assistance. This includes the full amount of capitation payments made to a Managed Care Organization (MCO) for medical and dental coverage, regardless of service use or how much the managed care entity paid for services.

Additional information may also be found at the website:

<https://dhs.iowa.gov/ime/members/members-rights-and-responsibilities/estate-recovery>

or contact:

**Medicaid Member Services Toll Free: 800-338-8366
515-256-4606 (Des Moines area)
or**

**Iowa Estate Recovery Program Toll Free: 1-877-463-7887
8:00 a.m. – 5:00 p.m., Monday – Friday**

Discrimination is Against the Law

The Iowa Department of Human Services (DHS) complies with applicable federal civil rights laws to provide equal treatment in employment and provision of services to applicants, employees, and clients and does not discriminate on the basis of race, color, national origin, age, disability or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

DHS:

- ◆ Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- ◆ Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Iowa Medicaid Member Services at 1-800-338-8366.

If you believe that DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: DHS, Office of Human Resources, by emailing contactdhs@dhs.state.ia.us or in writing to:

DHS Office of Human Resources
Hoover State Office Building, 1st floor
1305 East Walnut Street
Des Moines, IA 50319-0114

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the DHS Office of Human Resources is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

