HOME AND COMMUNITY BASED SERVICES
PHYSICAL DISABILITY WAIVER
INFORMATION PACKET

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

GENERAL PARAMETERS

- PD Waiver services are designed to be flexible to meet the needs of each member. The following services are available:

    - **Consumer Directed Attendant Care**
    - **Home and Vehicle Modification**
    - **Personal Emergency Response**
    - **Specialized Medical Equipment**
    - **Transportation**
    - **Consumer Choices Option**

The services that are considered necessary and appropriate to meet the member's needs will be determined through an interdisciplinary team consisting of the member, DHS service worker or case manager, service provider(s) and other persons the member chooses.

- All members will have a comprehensive service plan developed by a DHS service worker or case manager in cooperation with the member.

- The member must have a physical impairment as their disability

- Members shall access all other services for which they are eligible and which are appropriate to meet their needs as a precondition of eligibility for the PD Waiver.

- A comprehensive service plan must be developed and reviewed annually.

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

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

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

- PD Waiver services cannot be provided when a person is an inpatient of a medical institution.

- The member must need and use, at a minimum, one unit of waiver service during each quarter of the calendar year.

- The total cost of the array of physical disability wavier services cannot exceed $672.00 per month.

- The member must be ***ineligible*** for the Intellectual Disability (ID) Waiver.

- The member must be eligible for Medicaid under SSI, SSI-related, FIP, or FIP related coverage groups or eligible under the special income level of 300 percent of the maximum monthly Supplemental Security Income coverage group consistent with a level of care in a medical institution.

- Following is the hierarchy for accessing waiver services:
  Private insurance
  Medicaid and/or EPSDT (Care For Kids)
  Physical Disability Waiver services

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

MEMBER ELIGIBILITY CRITERIA

Members may be eligible for HCBS PD 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

- Have a physical disability

- Be between the age of 18 through 64 years

- Be blind or disabled as determined by the receipt of Social Security Disability benefits or by a disability determination made through the Division of Medical Services

- Be ineligible for the HCBS ID Waiver

- Be determined eligible for Medicaid (Title XIX). Members may be Medicaid eligible prior to accessing waiver services or be determined eligible through the application process for the waiver program. Additional opportunities to access Medicaid may be available through the waiver program even if the member has previously been determined ineligible.

- Have the ability to hire, supervise, and fire the HCBS PD service provider as determined by the DHS service worker or case manager. The member must be willing to do so or have a guardian named by probate court or an attorney in fact under a durable power of attorney for health care who will assume this responsibility on behalf of the member

- Be determined by the Iowa Medicaid Enterprise, Medical Services to need one of the following levels of care:
  - Intermediate Care Facility (ICF)
  - Skilled Nursing Facility (SNF)

- For the consumer choice option, not be living in a residential care facility

- Use a minimum of one unit of service per calendar quarter.

SERVICE DESCRIPTIONS

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

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 for health care shall be responsible for selecting the individual or agency that will provide the components of the CDAC services to be provided.

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

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

Non-skilled services may include but are not limited to: Dressing, hygiene, grooming, bathing supports, wheelchair transfer, ambulation and mobility, toileting assistance, meal preparation, cooking, eating and feeding, housekeeping, medications ordinarily self-administered, minor wound care, employment support, cognitive assistance, fostering communication, and transportation.

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

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

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

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

CDAC cannot replace a less expensive service.

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

An individual CDAC provider <u>cannot</u> be the recipient of respite services provided on behalf of a member receiving HCBS PD services.

The cost of nurse supervision, if needed

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

- The service worker or case manager should be aware of and have knowledge of the specific services included in the assisted living facility contract to ensure the following:
  - That assisted living facility services are not duplicative of CDAC services
  - Knowledge of how member needs are being addressed
  - Awareness of member unmet needs that must be included in the care plan
- CDAC payment does not include costs of room and board

- Each member must be determined by Iowa Medicaid Enterprise, Medical Services to meet intermediate care 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.

UNITS: A unit is 15 minutes

MAXIMUM The service worker or case manager, working with the member and the interdisciplinary team, establishes an amount of dollars that

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

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

It may be important for the 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.

HOME AND VEHICLE MODIFICATION (HVM)

WHAT: Physical modifications to the home and/or vehicle to assist with the health, safety and welfare needs of the member and to increase or maintain independence. All modification requests are reviewed individually and a determination is made regarding the appropriateness of the modification request.

WHERE: In/on the member's home and/or vehicle

DOES NOT INCLUDE: Modifications, which increase the square footage of the home, items for replacement which are the responsibility of the homeowner/landlord, vehicle purchase, fences, furnaces or any modifications or adaptations available through regular Medicaid.

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

MAXIMUM: The member is eligible for up to $6,366.64 per year.

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

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

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

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

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

SPECIALIZED MEDICAL EQUIPMENT

WHAT: Medically necessary equipment (as determined by a medical professional, i.e. PT, OT, nurse, licensed psychologist, speech therapist, etc.) for personal use by the member, which provides for the safety and health of the individual but are normally not funded by Medicaid, the educational system or vocational rehabilitation programs and are not provided by voluntary means. This includes, but is not limited to: Electronic aids and organizers, medicine-dispensing devices, communication devices, bath aids and non-covered environmental control units.

Repair and maintenance costs of the specialized medical equipment purchased

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

UNIT: A unit is the cost of the item.

MAXIMUM: Up to $6,366.64 per year may be allocated for the purchase and repair of specialized medical equipment.

TRANSPORTATION

WHAT: Transportation services may be provided for members to conduct business errands, to complete essential shopping, to receive medical services not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation.

WHERE: In the community as identified in the comprehensive service plan

DOES NOT INCLUDE: Cost of medical transportation reimbursable through medical transportation funding

UNITS: The units are as follows:

Per mile, per trip
Or Rate established by an Area Agency on Aging for all others

CONSUMER CHOICES OPTION

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

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

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

- Consumer Directed Attendant Care (unskilled)
- Home and Vehicle modification
- Specialized Medical Equipment
- Transportation

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

UNITS: A monthly budget amount is set for each member

APPLICATION PROCESS

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

Please respond immediately to correspondence from an income maintenance worker or DHS service worker or 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 PD Waiver is made with an Income Maintenance worker (IM) 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 will process the application and refer the member to a DHS service worker or case manager.
    - For adults applying for the PD Waiver, an appointment will be scheduled with the IM worker. Documentation necessary to complete this contact may include:
        - Financial records
        - Title XIX card
        - Letter of Medicaid Eligibility
        - Verification of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) or State Supplemental Assistance (SSA) eligibility, if applicable. If assistance is not currently being received, a request may be made to apply at the local Social Security office.

2. The Iowa Medicaid Enterprise, Medical Services Unit will review the Physical Disability Waiver Assessment Tool to determine if member needs require ICF or skilled nursing level of care.
    - If the member does not meet level of care, the IM 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. An interdisciplinary team meeting is conducted to determine the services that are needed, the amount of service to be provided and the provider(s) of the services. The interdisciplinary team meeting will be attended by the member/family, the DHS service worker or case manager, PD waiver service provider(s), and may also include other professional or support persons. The end result of the interdisciplinary team decisions will be a service plan developed by the DHS service worker or case manager.

4. The DHS service worker or case manager will issue a Notice of Decision if the member is approved to receive PD Waiver services.