

# 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 consumers in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective.

## GENERAL PARAMETERS

- BI Waiver services are individualized to meet the needs of each consumer. The following services are available:
  - **Adult Day Care**
  - **Behavioral Programming**
  - **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**
- The services that are considered necessary and appropriate to meet the consumer's needs will be determined through an interdisciplinary team consisting of the consumer, Medicaid case manager, service provider(s) and other persons the consumer chooses.
- All consumers will have a service plan developed and reviewed by a certified case manager for the BI Waiver in cooperation with the consumer. This plan must be completed prior to implementation of services. The service plan for consumers 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 EPSDT (Care For Kids) plan(s).
- Consumers 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.
- A service plan must be developed and reviewed annually.
- The consumer 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 service cannot be simultaneously reimbursed with another Medicaid waiver service or a Medicaid service.
- BI Waiver services cannot be provided when a consumer is an inpatient in a medical institution.

- Consumers must need and use at least one unit of the case management service during each quarter of the calendar year. In addition, the consumers 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:
  - Private insurance
  - Medicaid and/or EPSDT (Care For Kids)
  - Brain Injury Waiver services
- The total cost of BI Waiver services cannot exceed \$2730 per month.
- A designated number of consumers (payment slots) can be served under the HCBS BI program.
- Funding must be available either through the consumer's county of legal settlement or the State of Iowa.
- Assistance may be available through the In-Home Health Related Care program and the Rent Subsidy Program in addition to services available through the Brain Injury Waiver.

## CONSUMER ELIGIBILITY CRITERIA

### Consumers 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 IAC 441--83.81(249A) The Iowa Foundation for Medical Care (IFMC) will confirm the brain injury diagnosis.
- Be determined eligible for Medicaid (Title XIX). Consumers may be Medicaid eligible prior to accessing waiver services or be determined eligible through the application process for the waiver program. Additional opportunities to access Medicaid may be available through the waiver program even if the consumer has previously been determined ineligible.
- Be between the ages of 1 month and 64 years
- Be determined by the Iowa Foundation for Medical Care (IFMC) to need a level of care which would include one of the following:
  - Intermediate Care Facility for the Mentally Retarded (ICF/MR)
  - Intermediate Care Facility (ICF)
  - Skilled Nursing Facility (SNF)
- Be determined by the Iowa Medicaid Enterprise, Medical Services to be able to live in a home or community based setting where all medically necessary service needs can be met by the BI Waiver

## SERVICE DESCRIPTIONS

- **PLEASE NOTE:**

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

### ADULT DAY CARE

- WHAT:** Adult day care is an organized program of supportive care in a group environment. The care is provided to consumers 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
- UNITS:** A unit is:  
Half day - 1 to 4 hours  
**or**  
Full day - 4 to 8 hours  
**or**  
Extended day - 8 to 12 hours

### BEHAVIORAL PROGRAMMING

- WHAT:** Individually designed strategies to increase the consumer's appropriate behaviors and decrease any maladaptive behaviors which interfere with the consumer'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 consumer's home or community based on the consumer's need for intervention. Not in the provider's home.
- UNIT:** A unit is a 15-minute increment.

### CASE MANAGEMENT SERVICES

- WHAT:** The goal of case management is to enhance the consumer's ability to exercise choices, make decisions, and take risks that are typical of life, and fully participate in the community.
- Case management activities include the following:
- A comprehensive diagnosis and evaluation
  - Assistance in obtaining appropriate services and living arrangements
  - Coordination of service delivery
  - Ongoing monitoring of the appropriateness of services and living arrangements
  - Crisis assistance to facilitate referral to the appropriate providers
- WHERE:** In the consumer's home and community. Not in the provider's home.
- UNIT:** A unit is a monthly reimbursement.

## CONSUMER DIRECTED ATTENDANT CARE (CDAC)

**WHAT:** Assistance to the consumer with self-care tasks that the consumer would typically do independently if the consumer was otherwise able. An individual or agency, depending on the consumer's needs, may provide the service. The consumer, 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 & 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. Employment support includes assistance needed to go to or return from place of employment and assistance with job-related tasks while the consumer is on the job site.

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

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

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

**DOES NOT INCLUDE:** Daycare, babysitting, respite, room and board, parenting, case management, cost of transportation or 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 consumer or parent or stepparent of a consumer aged 17 or under.

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

The cost of nurse supervision, if needed

**UNITS:** A unit is:  
One hour  
**or**  
One 8 to 24 hour day

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

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

- The case manager should be aware of and have knowledge of the specific services included in the assisted

living facility contract to ensure the following:

- That assisted living facility services are not duplicative of CDAC services
- Knowledge of how consumer needs are being addressed
- Awareness of consumer unmet needs that must be included in the care plan
- CDAC payment does not include costs of room and board
- Each consumer must be determined by IFMC to meet ICF/MR, nursing facility or skilled nursing facility level of care
- The CDAC fee is calculated based on the needs of the consumer and may differ from individual to individual.

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

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

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

## FAMILY COUNSELING AND TRAINING

**WHAT:** Face-to-face mental health services that help the consumer, the consumer'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 consumer'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 is one hour.

## HOME AND VEHICLE MODIFICATIONS (HVM)

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

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

1. Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
2. Bathtubs and toilets to accommodate transfer, special handles and hoses for showerheads, water faucet controls, and accessible shower and sink areas.
3. Grab bars and handrails.
4. Turnaround space adaptations.
5. Ramps, lifts, and door, hall and window widening.
6. Fire safety alarm equipment specific for disability.
7. Voice activated, sound activated, light activated, motion activated and electronic devices directly related to consumer's disability.
8. Vehicle lifts, driver specific adaptations, remote start systems, including such modifications already installed in a vehicle.
9. Keyless entry systems.
10. Automatic opening device for home or vehicle door.
11. Special door and window locks.
12. Specialized doorknobs and handles.
13. Plexiglass replacement for glass windows.
14. Modification of existing stairs to widen, lower, raise, or enclose open stairs
15. Motion detectors.
16. Low pile carpeting or slip resistant flooring.

17. Telecommunications device for people who are deaf
18. Exterior hard surface pathway.
19. New door opening.
20. Pocket doors
21. Installation or relocation of controls, outlets, and switches.
22. Air conditioning and air filtering if medically necessary.
23. Heightening of existing garage door opening to accommodate modified van.
24. Bath chairs.

**DOES NOT INCLUDE:** Modifications that increase the square footage of the home, items for replacement that 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 consumer is eligible for up to \$6000 per year.

If the amount of the modification is allocated monthly, the monthly amount must be included in the \$2650.00 monthly dollar cap for up to \$500 per month.

## 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 services shall provide experiences for each consumer's social, emotional, intellectual, and physical development. The service will include comprehensive developmental care and any special services for a consumer 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 consumer's usual caregivers to be employed. Interim medical monitoring and treatment may also be used after the death of a usual caregiver. Interim medical monitoring and treatment services may include supervision for the child during transportation to and from school when not available through school or other sources. Interim medical monitoring and treatment 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:** 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, not be the spouse of the consumer or parent or stepparent of a consumer age 17 or under. The provider cannot be the usual caregiver. As determined by the usual caregiver, the provider must be qualified by training or experience. A licensed medical professional on the consumer'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

Must not be used for 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 that 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:** A unit is one hour.

**MAXIMUM:** Twelve (12) one-hour units of service per day

### PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

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

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

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

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

### PREVOCATIONAL SERVICES

**WHAT:** Prevocational services prepare a consumer for paid or unpaid employment. It includes teaching the consumer job readiness skills that may include the following: following directions, attending to tasks, task completion, problem solving, and safety and mobility training. Consumers may not receive a monetary wage during prevocational services.

**WHERE:** In a rehabilitation center or any other type of community setting where the consumer's need for this service can be met. Can be provided in the consumer's home but not the provider's home.

**DOES NOT INCLUDE:** Similar services that are available from the Division of Vocational Rehabilitation Services or from an educational system. The service worker/case manager must first contact DVR to see if consumer would qualify for Division of Vocational Rehabilitation Services funding.

Paid work in a workshop setting

Assisting a consumer in learning tasks or skills for a specific job

**UNIT:** A unit is one day.

## RESPITE

- WHAT:** Respite care services are services provided to the consumer that gives temporary relief to the usual caregiver and provides all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.
- **Specialized respite** means respite provided at a ratio of one or more staff to one consumer 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 consumers.
  - **Basic individual respite** means respite provided at a ratio of one staff to one consumer 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 consumer's home, another family's home, camps, organized community programs (YMCA, recreation centers, senior citizens centers, etc.), ICF/MR, RCF/MR, hospital, nursing facility, skilled nursing facility, assisted living program, adult day care center, foster group care, foster family home or DHS licensed daycare.
- Respite provided outside the consumer's home or outside a facility in locations covered by the facility's licensure, certification, accreditation, or contract must be approved by the parent, guardian, or primary caregiver and interdisciplinary team, and must be consistent with the way the location is used by the general public. Respite in these locations may not exceed seventy-two (72) continuous hours.
- DOES NOT INCLUDE:** Services shall not be reimbursable if the living unit is otherwise reserved for persons on a temporary leave of absence.
- Respite cannot be provided to consumers residing in the family, guardian or usual caregiver's home during the hours in which the usual caregiver is employed unless it is in a camp setting.
- Respite shall not be simultaneously reimbursed or provided with duplicative services under the waiver.
- UNITS:** A unit is one hour. Services are limited by the monthly maximum available for all waiver services.
- MAXIMUM UNITS:** Fourteen consecutive days of 24-hour respite care may be reimbursed  
**and**  
Respite services provided to three or more individuals for a period exceeding 24 consecutive hours for individuals who require nursing care because of a mental or physical condition must be provided by a licensed health care facility as described in the Iowa Code chapter 135C.

## SPECIALIZED MEDICAL EQUIPMENT

- WHAT:** Specialized medical equipment is medically necessary equipment as determined by a medical professional (i.e. PT, OT, nurse, licensed psychologist, speech therapist). It is designed for the personal use by the consumer 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 consumer's home or community. Not the provider's home.
- UNIT:** A unit is the cost of the item.
- MAXIMUM** The annual maximum is \$6000.00

## SUPPORTED COMMUNITY LIVING (SCL)

- WHAT:** SCL provides one to twenty-four hours of support per day based on the individual's needs.
- This service is designed to assist the consumer with daily living needs. Assistance may include, but is not limited to: Personal and home skills, community skills, personal needs, and transportation and treatment services.
- WHERE:** Consumers can receive SCL in the family home, the guardian home or other typical community settings (i.e., houses, apartments, condominiums, townhouses, trailers, etc.) Not 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:** Transportation to/from work or a day program, room and board costs, academics, medical services, vocational services, daycare, babysitting, parenting or case management
- UNITS:** A unit is:
- One hour
  - or
  - One day
- A daily rate applies to consumers 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 consumers who receive on-site staff supervision for 19 or more hours during a 24-hour day.
- MAXIMUM UNITS:** Daily Rate: 365 days per year or 366 days during a leap year  
Hourly Rate: 8,395 hours per state fiscal year or 8,418 hours during a leap year

## SUPPORTED EMPLOYMENT (SE)

- WHAT:** Individualized services associated with obtaining and maintaining competitive paid employment for individuals, because of disability, require intense and ongoing support to perform in a work setting
- The two components of this service are:
- **Activities To Obtain A Job**  
These are services provided to obtain competitive employment. Any of the following activities may be included:
    - Initial vocational and educational assessment to develop interventions that affect work
    - Job development activities
    - On-site vocational assessment prior to employment
    - Disability-related support for vocational training or paid internships
    - Assistance in learning skills necessary for job retention
  - **Supports To Maintain Employment**  
These are services provided to maintain competitive employment. Any of the following activities may be included:
    - Work-related behavioral management
    - Job coaching
    - On-the-job or work-related crisis intervention
    - Assisting with skills related to paid employment including communication, problem solving and safety
    - Consumer directed attendant care
    - Time management
    - Grooming

- Employment-related supportive contacts
  - Transportation between work or between activities related to employment. Other forms of transportation must be attempted first.
  - On-site vocational assessment after employment
  - Employer consultation
- Enclave
    - Maintaining employment may include services associated with sustaining consumers in a team of no more than 8 individuals with disabilities in a teamwork or enclave setting.

**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.

**FOR WHOM:** Consumers age 16 or older

**DOES NOT INCLUDE:** Consumers who are eligible for similar services from the Division of Vocational Rehabilitation Services  
 Consumers who are eligible for similar services from educational services  
 Services involved in placing or maintaining consumers in day activity, work activity or sheltered workshop programs  
 Supports for volunteer work or unpaid internships  
 Tuition for educational or vocational training  
 Individual advocacy that is not consumer specific

**UNITS:** One job placement                      Activities To Obtain A Job  
 One hour    Supports To Maintain Employment

**MAXIMUM UNITS:** Activities To Obtain A Job  
 Maximum of 3 job placements per 12 month period if the individual has been in paid competitive employment for a minimum of 30 consecutive days between job placements  
 Supports To Maintain Employment  
 Up to 40 hours per week as needed by the consumer

<b>TRANSPORTATION</b>
-----------------------

**WHAT:** Transportation services for consumers to conduct business errands, essential shopping, to receive medical services, to travel to and from work or day programs, and to reduce social isolation

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

**DOES NOT INCLUDE:** Transportation simultaneously reimbursed with transportation costs that may be included in an SCL rate or Medical Transportation that is reimbursable through medical transportation funding

**UNIT:** The units are as follows:  
                   State per mile rate for individual providers  
                   **or**  
                   Rate established by an Area Agency on Aging for all others

## APPLICATION PROCESS

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

Please respond immediately to correspondence from an income maintenance worker or Medicaid 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 Income Maintenance worker (IM) at the local DHS office. The IM Worker will secure a payment slot or put the consumer's name on a waiting list. Upon availability of a payment slot, the IM will process the application and refer the consumer to a Medicaid case manager (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.
2. An assessment tool, the Brain Injury Waiver Functional Assessment Form 470-3349 is completed by the Medicaid case manager or a facility discharge planner.
3. The Iowa Medicaid Enterprise, Medical Services will review the Brain Injury Waiver Functional Assessment to determine if consumer needs require ICF/MR, skilled nursing or ICF level of care.
  - If the consumer does not meet level of care, the IM will send a Notice of Decision (NOD) notifying the consumer of the denial. The consumer has the right to appeal the decision. The appeal process is explained on the NOD.
4. An interdisciplinary team meeting is conducted to determine the services that are needed, the amount of service to be provided and the provider(s) of the services. The interdisciplinary team meeting will be attended by the consumer/family, Medicaid case manager, BI 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 Medicaid case manager.
5. The Individualized Services Information System (ISIS) process must be completed with the culmination of an approved service plan prior to the implementation of services. An approved service plan recorded in the ISIS system authorizes payment for BI Waiver services.
6. The Medicaid case manager will issue a Notice of Decision if the consumer is approved to receive BI Waiver services.