MEDICAID HOME AND COMMUNITY BASED SERVICES
BRAIN INJURY WAIVER

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, which are considered necessary and appropriate for the consumer will be determined through an interdisciplinary team consisting of the consumer, DHS service worker or 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 which are appropriate to meet their needs as a precondition of eligibility for the BI Waiver.
- A service plan must be developed 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:
  1. Family, friends or natural supports
  2. Private insurance
  3. Medicaid and/or EPSDT (Care For Kids)
  4. Brain Injury Waiver services
- The total cost of BI Waiver services does not have a monthly cap (details can be found in DHS Informational Letter no. 2030-MC-FFS)
- A designated number of consumers (payment slots) can be served under the HCBS BI program.
- 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 Medical Services Unit of the Iowa Medicaid Enterprise 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.
- No age cap for this program.
- Be determined by the Iowa Medicaid Enterprise 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 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, 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

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.

BEHAVIORAL PROGRAMMING

Individually designed strategies to increase the consumer's appropriate behaviors and decrease any maladaptive behaviors that interfere with the consumer's ability to remain in the community. This may include, but is not limited to clinical redirection, token economies, reinforcement, extinction, modeling, and over learning.

CASE MANAGEMENT SERVICES

The goal of case management is to enhance the consumer's ability to exercise choices, make decisions, and take risks which are a 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

CONSUMER DIRECTED ATTENDANT CARE (CDAC)

Assistance to the consumer with self-care tasks, which 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 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, wound care, employment support, cognitive assistance, fostering communication, and transportation.

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.

Through the Waiver Prior Authorization process, the Medical Services Unit of the Iowa Medicaid Enterprise will review the CDAC agreement and units of CDAC service requested to determine if the units requested are medically necessary. *The consumer's or the consumer's parent'(s)or guardian'(s) ability to manage all aspects of Consumer Directed Attendant Care is a measure of whether this service is appropriate for the consumer. The consumer or the consumer's parents'(s) or guardian'(s) must be able and willing to manage for the consumer to receive Consumer Directed Attendant Care.*

FAMILY COUNSELING AND TRAINING

Face-to-face mental health services, which 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.

HOME AND VEHICLE MODIFICATIONS (HVM)

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.

SUPPORTED COMMUNITY LIVING (SCL)

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 training, individual advocacy, community skills training, personal environment support needs, and transportation and treatment services.

INTERIM MEDICAL MONITORING AND TREATMENT (IMMT)

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. Services must be ordered by a physician. Services under the state plan, including home health agency services must be exhausted before IMMT services are accessed Interim medical monitoring and treatment services shall provide experiences for each consumer's social, emotional, intellectual, and physical development. The service will include comprehensive development care and any special services for a consumer with special needs; and will 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

PERSONAL EMERGENCY RESPONSE or PORTABLE LOCATOR SYSTEM (PERS)

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

A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon 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

PREVOCATIONAL SERVICES

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Prevocational services provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings. 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

RESPITE

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 on a nurse to consumer ratio of one to one or higher 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 on a staff to consumer ratio of less than one to one.
- **Basic individual respite** means respite provided on a staff to consumer ratio of one to one or higher for individuals without specialized medical needs that would require care by a licensed registered nurse or licensed practical nurse.

SPECIALIZED MEDICAL EQUIPMENT

Medically necessary equipment (as determined by a medical professional, i.e. PT, OT, nurse, licensed psychologist, speech therapist, etc.) For personal use by the consumer 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.

SUPPORTED EMPLOYMENT (SE)

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"Supported employment" means the ongoing 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 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.

- Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

- Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce

- Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities

TRANSPORTATION

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

CONSUMER CHOICES OPTION

The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer has the authority to purchase goods and services and may choose to employ providers of services and supports. The consumer's department service worker or Medicaid targeted case manager determines the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. Services from those described previously, which may be included in determining the individual budget amount for a consumer in the HCBS brain injury waiver:

- **Adult Day Care**
- **Supported Community Living**
- **Home and Vehicle Modifications**
- **Prevocational Services**
- **Basic Individual Respite Care**
- **Transportation**
- **Supported Employment**
- **Specialized Medical Equipment**

A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer's home or at an integrated community setting:

- Self-directed personal care services, which are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the consumer remain in the home and community.
- Self-directed community supports and employment, which are services that support the consumer in developing and maintaining independence and community integration.
- Individual-directed goods and services, which are services, equipment, or supplies, not otherwise provided through the Medicaid program that address a need identified in the consumer's service plan.

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 slot, the IM will process the application and refer the consumer to a Medicaid Case Manager (CM). 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 to complete this contact may include medical records which indicate a brain injury diagnosis, financial records, title XIX card, letter of Medicaid eligibility and 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 facility discharge planner or the Medicaid Case Manager.

3. The Iowa Medicaid Enterprise, Medical Services Unit will review the Brain Injury Waiver Functional Assessment to determine if consumer needs require Intermediate Care Facility for Persons with Intellectual Disabilities ICF/ID, skilled nursing or Intermediate Care Facility(ICF, also known as nursing facility) level of care. If the consumer does not meet financial eligibility, 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 Medicaid case manager will issue a Notice of Decision notifying the consumer of the department's decision regarding level of care for the BI Waiver. The consumer has the right to appeal the level of care decision. The appeal process is explained on the NOD.

For additional information contact LeAnn Moskowitz, Program Manager, at (515) 256-4653 or lmoskow@dhs.state.ia.us

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