



Senior Companions

Make Independence a Reality

MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVERS

A GUIDE FOR SENIOR COMPANION PROGRAMS NOVEMBER 2008



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Medicaid Home and Community-based Services Waivers A Guide for Senior Companion Programs

Introduction

This Guide, designed for Senior Companion project directors, provides information on an important potential source of financial support for their projects—Medicaid Home and Community-Based Services (HCBS) waiver programs. HCBS waivers are options that states have to provide a wide range of home and community-based services to financially eligible people who meet the state’s criteria for needing nursing home care. As of 2007, 20 Senior Companion projects in 10 states were providers under HCBS waivers. These projects are described in *Appendix I*. HCBS waivers provided these Senior Companion projects with more than \$1 million in funding to expand volunteer services and serve more clients. See *Appendix II* for a summary of HCBS waiver funding to projects over the last 6 years.

Why Should Senior Companion Program Grantees Participate in Medicaid HCBS Waivers?

Participation in Medicaid HCBS waivers is beneficial to the Senior Companion program because it:

- Provides additional funding for the services provided by Senior Companion projects;
- Broadens the financing base for Senior Companion programs, making Senior Companion programs less dependent on any single source of funding; and
- Enables the program to serve an increased number of older people in need of services and to provide support for senior volunteers.

To better understand the Home and Community-Based Services waiver you must first have a working knowledge of the Medicaid Program. Chapter 1 of this document will provide you with this information. Participation in these waivers, however, requires careful planning, advance work, and follow-up. The following sections outline the steps that Senior Companion projects can take to have their services reimbursed through HCBS waiver programs.

What's in This Guide?

This guide explores the successful experiences and challenges of participating in waiver programs and is designed to provide project directors with information on how to use HCBS waivers to serve more clients. The Guide provides strategic guidance on how to work with key state decision makers to enable Senior Companion programs to participate in HCBS waiver programs. Throughout the Guide, we quote Senior Companion project directors about their experiences with the HCBS waiver program. In addition to detailed information about the overall Medicaid program and HCBS waivers, the Guide also provides more limited information about the optional Medicaid personal care benefit, new HCBS options provided by the Deficit Reduction Act of 2005, and state-funded home care programs. Senior Companion projects should consider becoming vendors under those Medicaid options as well.

Participation in the elderly waiver program is well worth the effort it takes to become a provider. The waiver allows us to expand our program, is a great source of revenue, and has allowed us to diversify our funding sources. The dollars we receive are tied to the number of clients we serve, and at the current Medicaid rate, it more than covers the cost of serving the clients. Since we started serving elderly waiver participants, we serve a significant number of additional clients, and we do it without losing money in the process.

—John Pribyl, Lutheran Social Services Senior Companion Program, St. Paul, Minnesota

We've been a Medicaid waiver provider for a number of years and having the extra funding ...to benefit the Companions has been a godsend. We use it to target those people who especially need our services because they have low incomes and the physical need to have a Companion.

—Carla Boswell, Southwestern Illinois College—Programs and Services for Older Persons, Belleville, Illinois

A major motivator to become a Medicaid waiver provider is the supplemental program funding we get for providing services. It has helped our program expand to serve more seniors in the community.

—Mary Brock, Senior Companion Program of Nevada, Sparks, Nevada

Chapter 1

The “Regular” Medicaid Program

Medicaid is a joint federal-state program that pays for the costs of medically necessary care for eligible low-income people. Each state operates its [Medicaid program](#) under a State Plan that has been approved by the Centers for Medicare & Medicaid Services (CMS) in the U.S. Department of Health and Human Services. To understand how the Medicaid program works, it is important to understand several of its key features.

Medicaid Is Not a Single Program

Unlike Medicare, Medicaid is administered primarily by the states. Moreover, states have substantial flexibility to design their Medicaid programs as they like within broad federal requirements. As a result, state Medicaid programs can vary considerably in the way they operate, whom they serve, what services are provided, and how providers are reimbursed. Some Medicaid programs are relatively limited in who and what they cover; others are quite comprehensive. Information about individual state Medicaid programs can be found at the Henry J. Kaiser Family Foundation [website](#). The National Association of State Medicaid Directors has a [map](#) with direct links to all Medicaid agencies.

Medicaid Has Three Key Components: Eligibility, Covered Services, and Eligible Service Providers

To understand the basics of a state’s Medicaid program, it is important to ask three questions:

1. ***Who is eligible for Medicaid?*** Eligibility for Medicaid is restricted to persons who have low incomes after subtracting high medical expenses. Medicaid does not cover all categories of all persons who have low incomes, but it does cover people aged 65 and older and younger persons who have disabilities severe enough to qualify them for disability payments through the Supplemental Security Income program.

Medicaid eligibility rules are very complex and vary by state. In general, however, older people living in the community who are eligible for Supplemental Security Income or, in some states, who have income less than the federal poverty level and who have financial assets of less than \$2,000 for individuals and \$3,000 for married couples are eligible for Medicaid. Supplemental Security Income provides cash benefits of up to about three-quarters of the federal poverty level to low-income people. Individuals are not eligible for Medicaid if they have home equity exceeding \$500,000 (\$750,000 at state option). Thirty-four states and the District of Columbia

also have “medically needy” Medicaid eligibility rules, which allow people with higher incomes who have substantial medical expenses to “spend down” to Medicaid income requirements. Almost all older people eligible for Medicaid and about a quarter of younger people with disabilities are also eligible for Medicare; these individuals are known as “dual eligibles.” Different financial and functional eligibility criteria apply to persons eligible for Medicaid HCBS waivers. Individuals who meet Medicaid’s financial eligibility requirements need to meet additional functional disability criteria to be eligible for HCBS waiver services. For those individuals not eligible to be covered under Medicaid, there are options in some states that allow them to be covered under a Medicaid HCBS waiver instead. As a result, the eligibility criteria for a Medicaid HCBA waiver are different than the eligibility criteria for Medicaid. Additionally, some states require an individual to meet the Medicaid eligibility requirements plus additional eligibility requirements in order to be eligible for a Medicaid HCBS waiver. Additional information on Medicaid eligibility can be found at the websites of [AARP](#) and the [Congressional Research Library](#).

2. ***What services does Medicaid cover?*** Federal law requires that state Medicaid programs cover 14 different services, including physician services, inpatient hospital services, nursing home care, and home health care.¹ State Medicaid agencies may cover additional services at their discretion; that is, certain services are optional. These services include mental health services, case management services, and inpatient psychiatric care. Personal care (i.e., help with the activities of daily living) is an optional service that was covered by 34 states and the District of Columbia in 2006. Many nonmedical home and community services, such as companion services, are not eligible to be covered as an optional service under most circumstances, although they are eligible under certain conditions established by the Deficit Reduction Act (see *Appendix III*). A state-by-state listing of covered services is available at the Henry J. Kaiser Family Foundation [website](#).
3. ***Who provides Medicaid-reimbursed services?*** Excluding hospitals and nursing homes, each state determines the standards that providers must meet to receive Medicaid funding. Service providers are often known as Medicaid “vendors.” Providers are assigned a vendor number that they use to bill Medicaid for covered services furnished to Medicaid-eligible individuals. Only providers with a Medicaid vendor number can be reimbursed by Medicaid.

¹The full list of mandatory services includes physician services, laboratory and x-ray services, inpatient hospital services, outpatient hospital services, early and periodic screening diagnostic and treatment (EPSDT) for individuals under 21, family planning and supplies, federally qualified health center services, rural health clinic, certified pediatric and family nurse practitioner services, nursing facility services for persons age 21 and older, and home health services.

Medicaid is funded with federal and state dollars. The federal government and the states jointly fund Medicaid. There is no cap on federal Medicaid payments to states. The percentage of Medicaid costs that the federal government pays—known as the Federal Medical Assistance Percentage (FMAP)—depends on each state’s per capita income, and will range from 50.00 to 75.84 percent of service costs in federal fiscal year 2009. In other words, for every dollar that the state spends on Medicaid services, the federal government will reimburse the state between \$0.50 and \$0.7584. States with lower per capita income have higher FMAPs; states with higher per capita income have lower FMAP rates. Because the FMAP varies by how each state’s per capita income relates to the national average, the rate changes somewhat from year to year. Information on the FMAP for each state is available at the Office of the Assistant Secretary for Planning and Evaluation’s [website](#). The state (and, in a few states, counties) is responsible for the remaining costs not paid by the federal government and that amount is sometimes called “the state match.”

Medicaid pays providers mostly on a fee-for-service basis. Medicaid pays most providers directly for Medicaid-covered services furnished to eligible individuals. The reimbursement methodology—the amount and how the payment rate is determined—is almost entirely up to the states. However, states must follow three basic rules: providers must accept Medicaid reimbursement as payment in full; the “methods and procedures” for making payments must be consistent with “efficiency, economy, and quality of care”; and the state’s reimbursement rate must be sufficient to attract enough providers so that services are as available to Medicaid beneficiaries as they are to the general population. As a practical matter, however, states have complete freedom in how they set reimbursement rates. Courts have not favored providers in lawsuits alleging inadequate payment rates.

Most states pay individual providers based on a “unit of service,” which may be a visit or a set amount of time. This is known as “fee-for-service reimbursement.” Some states have managed care organizations for older people to which Medicaid makes an overall payment to cover all of the services covered by the managed care contract. In these cases, individual providers must negotiate their reimbursement rates directly with the managed care organizations. Most managed care organizations participating in Medicaid provide only acute care, but some, including those in [Minnesota](#), [Texas](#), and [Wisconsin](#) have managed care plans that include at least some long-term care services which may be covered by the Medicaid HCBS waiver. In those instances where home and community services are provided by the managed care organization, Senior Companion programs must negotiate payment rates with the managed care organizations which can differ from the rate set by the state.

Chapter 2

Medicaid Waivers: An Overview

What Is a Waiver and Why Do States Use Them?

A Medicaid waiver is a provision in Medicaid law through which the federal government “waives” certain rules that normally govern the Medicaid program so that states may accomplish certain goals. When a state applies for a waiver, it is asking for the federal government’s permission to operate its Medicaid program in ways not normally allowed. Waivers give states more flexibility to design and operate their Medicaid programs—to deliver health and long-term care services in new ways, to reduce costs by using different service strategies, and to expand coverage to groups of people usually not eligible. The federal government can issue these waivers only under certain legislatively established conditions.

What Are the Different Types of Waivers?

States may obtain three different types of waivers:

- *HCBS waivers*—sometimes referred to as Section 1915(c) waivers: Allow states to cover certain long-term care services not normally covered under the Medicaid program; they also waive other requirements for operating a program, which will be discussed later.
- *Freedom of choice waivers*—sometimes referred to as Section 1915(b) waivers: Allow states to require enrollment in managed care plans, which may provide more coordinated care and reduce expenditures.
- Research and demonstration waivers—sometimes referred to as “Section 1115” waivers: Used by states to test new approaches to organizing and delivering care.

How Are Waivers Obtained?

To obtain a waiver, a state must develop and submit an application to CMS. The application must describe what it plans to do, when, and how. CMS evaluates applications based on their compliance with the particular waiver’s criteria. After review of the state’s application, CMS sends an “issues letter” to the state, outlining the programmatic or financial aspects of the proposed program that raise issues that must be resolved prior to approval. Subsequently, CMS provides the state a list of technical questions about the proposal.

Chapter 3

Home and Community-based Services Waivers

What Is a Home and Community-based Services (HCBS) Waiver?

Under Section 1915(c) of the Social Security Act, states may apply to CMS for Medicaid HCBS waivers designed to allow states greater flexibility to meet the needs of community-dwelling persons with long-term care needs.² The goal of the waivers is to substitute home and community services for nursing home and other institutional care. States have increasingly used HCBS waivers to balance their long-term care systems for three major reasons. First, they provide states with the means to control their HCBS expenditures. Second, they allow states to provide the comprehensive range of services that people with disabilities and chronic illnesses need. Third, they allow states to provide Medicaid eligibility to people who would not usually qualify financially for Medicaid coverage.

Medicaid HCBS waivers differ from the regular Medicaid program in six key ways:

- In the regular Medicaid program, beneficiaries who do not have significant long-term care needs may receive home and community services, such as personal care. However, because Medicaid HCBS waivers are intended to substitute for institutional care, states must limit eligibility for these waivers to people with relatively severe disabilities—Medicaid beneficiaries who need institutional care. For older people and younger Medicaid beneficiaries with long-term care needs, this means they must meet the criteria for admission to a nursing home. The need for nursing home care is determined based on medical and/or functional criteria and states vary considerably in the type of criteria they use. Some states have very stringent medical criteria or require a combination of medical and functional needs; others require only the latter. Thus, an individual who is severely impaired may be eligible for the HCBS waiver in one state but not another.
- In the regular Medicaid program, states cannot explicitly limit the number of people who use a service; the program is an “open-ended entitlement”—a legal obligation for the government to provide services to individuals who meet preestablished criteria regardless of the cost to the government. This characteristic of Medicaid makes states potentially vulnerable to large increases in expenditures for home and community services because

² See the [websites](#) of the [Henry J. Kaiser Family Foundation](#), [Center for Personal Assistance Services](#), and the [Centers for Medicare & Medicaid Services](#) (http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGL/08_WavMap.asp, <https://www.hcbswaivers.net/CMS/faces/portal.jsp>). For additional information on HCBS Waivers, Medicaid, and long-term care see *Appendix IV*.

of the potential for greatly increased use by the substantial number of people with disabilities who are not currently receiving paid services. In contrast, Medicaid beneficiaries are not legally “entitled” to waiver services even if they meet the financial, functional, and medical criteria. Under Medicaid HCBS waivers, states must specify to CMS the maximum number of people they will serve in the waiver during a year and cannot exceed that number without obtaining permission from CMS. Because the demand for waiver services is often greater than the number of people who can be served, many states establish waiting lists for waiver services. [State-by-state information](#) on HCBS waiver waiting lists for 2006 is available. Since not all states keep waiting lists and states vary in the methods used for keeping these lists, the numbers of people waiting for services is probably understated in these data.

- In the regular Medicaid program, states do not have to demonstrate that changes in policy do not increase expenditures. In contrast, HCBS waivers must be “budget neutral” —that is, the state must demonstrate that Medicaid costs with the waiver program will be no greater than Medicaid costs without. In most circumstances, this is measured for older people and younger persons with physical disabilities by assessing whether average Medicaid expenditures for beneficiaries of the waiver are the same or less than average Medicaid expenditures for nursing home residents.
- In the regular Medicaid program, Medicaid may cover only a fairly narrow list of home and community services, principally those provided by home health aides and personal care assistants. Under a waiver, states may cover a very wide range of long-term care services, including services not normally covered by Medicaid. These services include all of the long-term care services that can be covered under the State Plan, chore services, attendant care services, adult foster care, assisted living services, adult day health, habilitation, respite care, nonmedical transportation, home modifications, specialized medical equipment, personal emergency response systems, adult day care and adult companion services, and “other” services covered at the discretion of CMS. Medicaid HCBS waivers cannot pay for room and board.
- Most states limit financial eligibility to the “regular” Medicaid program to people whose income is equal to or less than the amount provided by the Supplemental Security Income program or slightly higher. Under HCBS waivers, states have the option to allow community-residing beneficiaries with incomes up to 300 percent of the federal Supplemental Security Income level (roughly two times the federal poverty level) to be eligible for Medicaid. Most states still require that unmarried beneficiaries have less than \$2,000 in financial assets, which disqualifies many low-income older people.
- In the regular Medicaid program, states may not limit available services to specific groups of people. For example, states are not allowed to cover personal care under their

State Plan only for young adults with traumatic brain injuries, excluding older adults with dementia. This prohibition ensures the “comparability” of services. Similarly, all covered services in the regular Medicaid program must be available in all parts of the state. This is the “statewideness” requirement. In contrast, states may operate waivers on a less-than-statewide basis and target waiver services to specific groups of Medicaid beneficiaries, such as older persons, persons with developmental disabilities, people with HIV/AIDS, children, or adults with traumatic brain injuries.

How Extensive Is the Use of HCBS Waivers?

In 2006, states operated 18 HCBS waivers for older people and 70 “Aged and Disabled Waivers” that serve both older adults and younger adults with physical disabilities. Every state and the District of Columbia has an HCBS waiver that provides services to older people except Arizona, which operates its entire Medicaid program under a Section 1115 research and demonstration waiver (Eiken and Burwell, 2007). In addition, states operated 209 other HCBS waivers, primarily for people with intellectual/developmental disabilities. In 2006, Medicaid expenditures for aged and aged/disabled waivers totaled about \$4.5 billion out of a total of \$25.4 billion for all HCBS waivers. In 2004, there were 507,000 participants who were older people or persons with physical disabilities (Kitchener et al., 2007).

Chapter 4

HCBS Waiver Programs and Senior Companion Services: Getting Started

Three key steps are needed to get started: identifying the state’s Medicaid agency, identifying the state’s Medicaid HCBS waiver programs, and obtaining key information about each waiver program to identify those that will best fit with Senior Companion projects.

Identify the State’s Medicaid Agency

Federal law requires states to designate one department to be responsible for the Medicaid program, called the “single state agency.” While this agency may contract with another agency or entity to administer HCBS waiver programs, such as Area Agencies on Aging, the lead agency has the final authority over Medicaid waiver programs. It is the lead agency that submits applications for a new waiver or to amend an existing waiver to include new services or serve new populations. The lead agency also must approve the qualification criteria for all Medicaid service providers. In some states, county departments of aging or human services or Area Agencies on Aging administer the waivers on a day-to-day basis.

To identify the Medicaid agency in your state, go to the [website](#) of the National Association of State Medicaid Directors and click on your state.

Identify Existing HCBS Waivers and the Populations They Serve

Most states have several HCBS waivers, which serve different populations or provide different services. Most commonly, HCBS waivers target specific populations. The most common types of waivers are those for:

- Adults aged 65 or older—Aged waivers;
- Working-age adults with physical disabilities—Disabled waivers;
- Adults aged 65 or older and working aged adults with physical disabilities—Aged and Disabled (A/D) waivers;
- Adults with acquired brain injuries or traumatic brain injury waivers—TBI waivers;
- Individuals with HIV/AIDS—HIV/AIDS waivers;
- Medically fragile children—MF waivers; and

- Children and adults with intellectual and other developmental disabilities—MR/DD waivers.

Senior Companion projects will be most interested in Aged and Aged/Disabled waivers. Knowing the target population in each waiver will enable the Senior Companion project director to determine which waivers serve a population they also serve or could serve.

The Center for Personal Assistance Services, operated by the University of California, San Francisco, maintains a website with detailed information about each state’s HCBS waivers. The [webpage](#) has links to the state’s own website for the waiver, which generally will have contact information for individuals who can provide more information about the program.

Obtain More Information About the Relevant HCBS Waivers

To find out if your Senior Companion project would be a good fit with an existing HCBS waiver, you will need to find out what areas of the state are covered by the waiver, how many people receive waiver services, what services are covered under the waiver, what are the provider qualifications, and what is the reimbursement rate. The answers to these questions will determine whether it is viable for Senior Companion projects to participate in the waiver.

Does the Waiver Program(s) Cover the Entire State or Only Certain Geographic Areas?

Most waivers operate in all parts of the state, but some are targeted to specific geographic areas. An HCBS waiver’s service area is a key determinant of the “fit” between the waiver program and the Senior Companion project. The UCSF-PAS [website](#) lists this information for some of the waivers. When not listed, the information can be obtained using the state contact information provided.

How Many People Are Served Under the Waiver Program(s)?

The number of people served by the different waiver programs will give Senior Companion project directors a sense of the potential market for Senior Companion services.

What Services Can Be Provided Through the State’s HCBS Waivers?

States can cover a very broad range of services through HCBS waivers. States vary in what services they cover in their HCBS waivers. Some states provide only one service—personal care—while others cover a comprehensive range of services. Services of particular interest to Senior Companion projects because they most closely parallel the types of services that the

programs provide are respite care, nonmedical transportation, chore services, companion services, and training and counseling services for unpaid caregivers. **Exhibit 1** below provides the definition of these services as listed in the federal HCBS [waiver application](#).

Exhibit 1: Federal Definitions of Selected Services Provided in HCBS Waivers

Service Type	Service Definition
Respite Care	Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility, approved by the state, which is not a private residence.
Nonmedical Transportation	Service offered to enable waiver participants to gain access to waiver and other community services, activities, and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the state plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant’s service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are used.
Chore Services	Services needed to maintain the home in a clean, sanitary, and safe environment. This service includes heavy household chores such as washing floors, windows, and walls; tacking down loose rugs and tiles; and moving heavy items of furniture to provide safe access and egress. These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third-party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service.
Companion Services	Nonmedical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry, and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan.
Training and Counseling Services for Unpaid Caregivers	Training and counseling services for individuals who provide unpaid support, training, companionship, or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or coworker who provides uncompensated care, training, guidance, companionship, or support to a person served on the waiver. This service may not be provided to train paid caregivers. Training includes instruction about treatment regimens and other services included in the service plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain the participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the participant. All training for individuals who provide unpaid support to the participant must be included in the participant’s service plan.

Source: Centers for Medicare & Medicaid Services. (2008). *Application for Section 1915(c) Home and Community-based Waiver: Instructions, Technical Guide and Review Criteria*. Baltimore, MD. Available at <https://www.hcbswaivers.net/CMS/faces/portal.jsp>.

However, the services a state may offer under the HCBS waiver authority are not limited to these definitions and states may define the services listed above in different ways. For example, one state may include light housekeeping within the definition of “companion services” and another state may not permit this activity. Knowing the service definition is very important for Senior Companion projects to determine whether they provide the services covered by the waiver. Examples of how some states define these services can be found in *Appendix V*.

What Are the Provider Qualifications for Each Waiver Service?

Each HCBS waiver has specific state-determined requirements that providers must meet to become a “vendor” of waiver services. Depending on the specific service, qualifications can include educational requirements, specified skills, years of experience, and completion of certain types of training.

Senior Companion project directors need to consider all information regarding provider qualifications to determine whether their programs may qualify as “vendors.” This information will also indicate whether Senior Companion volunteers have or could easily acquire the training and other qualifications needed to provide waiver services. Information on qualifications is usually available on the state waiver website or in state licensing regulations.

What Is the Reimbursement Rate for Each Service?

Each state Medicaid program sets its own reimbursement rates for waiver services. Except in managed care arrangements, the rate is based on a “unit of service,” which may be “visits” or “hours” or “half hours.” The Medicaid reimbursement rate will give Senior Companion project directors an indication of the level of revenue possible in relation to costs that programs might realize by becoming a waiver service provider. Some states may require that the provider agency fill out a “cost report,” which documents the agency’s expenses by category.

Chapter 5 Moving Forward

Once Senior Companion project directors have gathered information about relevant HCBS waivers in their state, they are ready to analyze whether there is a match between their projects and the waivers.

Assess Whether Senior Companion Project Services Are Covered in HCBS Waivers

This step involves comparing the services covered by the HCBS waivers and by the Senior Companion program to see if they are the same services for the same population.

Strategy 1: HCBS Waivers Cover Services Similar to Those Provided by Senior Companion Projects

In most states, HCBS waivers will cover the services provided by Senior Companion projects. In some cases, the services will be an exact match and the criteria for service providers will easily be met by Senior Companion volunteers. In other cases, the match may be less than ideal and a Senior Companion project may have to change some procedures, such as implementing different training requirements. Once the Senior Companion project complies with the rules for providers of HCBS waiver services, it will need to apply to become a vendor.

Strategy 2: Adding Senior Companion Services to HCBS Waivers When They Are Not Covered

If Senior Companion services are not covered by existing HCBS waivers, then it may be possible to add additional services to the waiver, most commonly at the time it is renewed by the state. Technically, it is possible for states to apply for a modification in the waiver at any time, but given the paperwork and effort involved, most states wait until the time of waiver renewal to make policy changes. Initial HCBS waivers are approved for 3 years. After the first renewal, subsequent renewals are required every 5 years.

Attempting to add Senior Companion services to an existing waiver is a strategy that requires Senior Companion project directors to spend considerable time and effort identifying, contacting, and working closely with key program and policy decision-makers – keep in mind that this time can be charged to the project. They must also be ready to present data to support their request to add Senior Companion services, which may also take considerable time to prepare.

Please note that OMB Circulars A-87, A-122 and A-21 do not allow grant funds to be used for the costs of “organized fundraising, including financial campaigns, endowment drives, solicitation of gifts and bequests, and similar expenses incurred solely to raise capital or obtain contributions.” When determining what staff activities are considered “organized fund raising”, the test is the purpose of the event or activity, not the amount of funds raised. Senior Corps project staff may disseminate information about the project’s activities, outcomes, and governing regulations. This includes responding to questions or providing information to state or local governments that may decide to contribute to the cost of or work with the program.

For further clarification on fundraising please visit the Manage Current Grants section of www.seniorcorps.gov.

When using this strategy, it is important for project directors to:

- Determine when the state Medicaid agency will begin the waiver renewal application, which may be a year or more before it is due;
- Determine the procedures that must be followed to amend the waiver (i.e., is the state legislature required to approve any change to the waiver?);
- Identify the Senior Companion service(s) that you want to be covered by the waiver *and document that they are needed*; and
- Determine the reimbursement rates that will cover the cost of providing the service(s) *and demonstrate that their provision will be cost-effective*.

Each proposal will be somewhat different, depending on the needs of the individual community and target populations to be served; the programmatic interests, priorities, and capabilities of the particular Senior Companion project; and state-specific aspects of the Medicaid program. Some guidelines, however, may be helpful to project directors as they develop these proposals.

Practical Guidance and Tips

The Most Common Objection: Federal Funding for Senior Companions Is Already Available

The most common objection to including Senior Companion projects as Medicaid waiver providers is that the projects already receive federal funds and “federal funds can’t match federal funds.” It is critical that Senior Companion project directors explain to state officials that the

project's Corporation for National and Community Service (CNCS) federal funding would in no way be used to "match" the federal Medicaid dollars. Instead, the services that would be funded through Medicaid would not receive any other federal funds and these services would be in addition to those provided through CNCS. In other words, waiver dollars enhance and expand the program beyond what the regular federal grant provides, allowing more service hours to be provided and more clients to be serviced. As a result, the waiver dollars do not duplicate funding from CNCS. Moreover, there are methods to keep funding sources separate even when volunteers serve both waiver and nonwaiver clients. For example, revenue can be categorized depending on its source, so that each category of client and volunteers is identified by a specific account number.

Decide Whom to Approach With Waiver Proposals

Early in the process, Senior Companion projects should identify which state agencies they need to approach with their proposals. These agencies include the state's Medicaid agency as well as any other agencies that administer HCBS waivers. Discussion with key contacts in an administering agency will help the Senior Companion project director determine the interests of the agency regarding:

- Services that might be provided—"companion services" or "respite care;"
- Populations who might be served with these new services; and
- Types of service providers whom the Medicaid agency will consider as vendors.

If the addition of new services must be approved by the state legislature, project directors should identify which legislators are likely to be receptive to the idea and discuss with them the possibility of their supporting or even championing the proposed addition.

Make the Case for Coverage of Senior Companions and Concisely Describe Their Services and Qualifications

In virtually all states, the Medicaid agency will want answers to two types of questions about adding services to an existing waiver:

- *Policy questions*, such as whether Medicaid rules allow what is being proposed and whether the services are worthwhile; and
- *Budget questions*, such as what the new services will cost and whether the waiver will remain budget neutral.

To ensure that Senior Companion services are covered by HCBS waivers, project directors have to market them. Marketing needs to demonstrate:

- The value of Senior Companion services to clients and to the Medicaid program; and
- That Senior Companions have a unique ability to provide both high-quality and cost-effective services.

It is a good strategy to approach decision-makers within administering agencies or in the Medicaid agency itself with specific language that they can use in their application to CMS to add services to an existing waiver. The following chapter provides information to help Project Directors make their case.

Chapter 6

Messaging and Marketing

Senior Companion projects that have successfully marketed their services to waiver programs stress that furnishing these services is a “win-win” situation. Senior Companions provide useful services to clients at a low cost to the state. Other specific messages that project directors may use in marketing their programs follow.

Message 1: Services Provided by Senior Companions Are Low Cost

Historically social service programs have served clients using a medical model. The mindset of the social service field has been that older people are a problem that must be taken care of, and they couldn't even consider that seniors could play a role in helping take care of other seniors in need.

When we first approached some top administrators to become a provider of elderly waiver services, someone asked “Why do I want to have more older people around to take care of?” Our problem was trying to convince not just administrators, but more importantly, case managers, that seniors are not just a problem, but can be at least a part of the solution.

—John Pribyl, Lutheran Social Services Senior Companion Program, St. Paul, Minnesota

One of the most important messages to convey to the state Medicaid agency is that providing low-cost companion and other services to waiver participants through the Senior Companion project can help to limit Medicaid long-term care costs. Some of the points to be made to the Medicaid agency are the following:

- If the state determines the cost of each provider or class of providers separately, then Medicaid expenditures will be less because Senior Companion projects can provide services at a lower rate than other providers. In most cases, because volunteers receive only a nominal stipend (\$2.65 per hour in 2008, compared to the median wage of personal and home care aides of about \$8.50 per hour in 2006), most Senior Companion project costs will be below the reimbursement rate paid to other providers.
- If a state pays all waiver providers of a particular service, including Senior Companion projects, the same rate, Senior Companion projects can provide “extra value” for the reimbursement rate they receive. For example, Senior Companion projects can provide additional service hours to clients with high levels of need at no additional charge to the Medicaid program. Alternatively, Senior Companion projects can demonstrate how the amount received above costs can be used to provide more volunteers with a stipend, thereby reaching more clients.

Message 2: Senior Companions Provide High-Quality Services and Will Meet the Needs of Waiver Participants

When case managers are designing a package of services for their clients, they can stretch their per day allotment for their clients tremendously if they use Senior Companions. Medical transportation in our area costs a minimum of \$65 to go to a grocery store. We reimburse Senior Companions 40 cents a mile. It is more cost-effective to use Senior Companions when somebody doesn't need health care. The cost savings motivates the case managers to use Senior Companions.

—Camillia Pisezna,
Region IV Senior
Companion Program, St.
Joseph, Michigan

Another important message to convey is that Senior Companion projects provide high-quality services. Some of the points that may be used to convey this message are the following:

- Waiver participants, particularly those who live alone, may be socially isolated. Senior Companions provide the social interaction participants need in addition to the other services they provide. Senior Companions are not merely “assistants” but serve as vital sources of support to the elderly.
 - Seniors tend to trust other seniors.
 - Senior Companions are trained and supervised by professional staff. Administrators of Medicaid waiver programs can be confident that services will be provided by trained, caring, and well-supervised individuals.
 - By meeting routine but essential needs, such as helping participants eat properly and keep scheduled medical appointments, Senior Companions help skilled health care professionals to work on problems requiring more education and training. They also can provide nurses and other health care professionals with their observations about changes in the clients' health status.
-
- Senior Companion volunteers who provide services are themselves low-income seniors (to be eligible for the program their income cannot exceed 125 percent of the federal poverty level). Their participation in the program actively engages them in service to their communities—a factor associated with physical and psychological well-being. They also receive a modest stipend to help them remain economically self-sufficient. Thus, the Senior Companion program can benefit both the waiver participants and the Senior Companion volunteers themselves.

Message 3: Senior Companions Can Help to Alleviate Workforce Shortages

People who age in place often are totally isolated; they have no family, they can't get out, and no one comes to see them. At least in a nursing home you have socialization and people around you. You may not like everybody but it's a community. The importance of companionship is critical to overall mental health.

The way I explain it is that we provide volunteer opportunities for these senior volunteers and if they didn't have this volunteer opportunity out in their communities with mental stimulation, exercise, and the good feelings you get from volunteering, these people would still be at home and soon would be on these care managers' case loads. Volunteering is keeping these seniors active and keeping them from becoming dependent themselves. That's a strong case to be made but it's one that care managers often have difficulty with.

—Camillia Pisegna, Region IV Senior Companion Program, St. Joseph, Michigan

The Senior Companion program provides a way to expand the workforce available to serve the growing number of people with long-term care needs. A recent study projected that the number of older people with disabilities will approximately double between 2000 and 2040, but the working-age population which typically provides long-term care services will grow only slowly during this period. Many communities already recognize the value of Senior Companion services and could use more volunteers. However, budget constraints limit recruitment, training, supervising, and supporting additional volunteers. Using Senior Companions in HCBS waivers can provide the financial resources to expand the pool of volunteers and serve more clients, thereby meeting community needs that otherwise might remain unmet.

It is important to continually emphasize the “win-win” theme. While Senior Companions provide useful services to waiver participants at low cost to the state, the waiver programs can also help to expand a vital community resource. This message may be especially helpful in enlisting the support of Area Agencies on Aging and the State Unit on Aging, which may be critical in states where

they play a major role in administering the waivers.

Chapter 7

Administrative and Program Considerations

Once the Medicaid Agency agrees to add services that can be provided by senior companions to a waiver, Senior Companion projects will have to address several administrative and program issues.

Matching Services With Participants

It is important that case managers have a clear understanding of what Companions can and cannot do while assisting their clients. Companions become frustrated when they are assigned to a client who requires more personal care than what they have been told they are allowed to do.

—Carla Boswell,
Southwestern Illinois College
—Programs and Services for
Older Persons, Belleville,
Illinois

People receiving Medicaid HCBS services, by definition, need the level of care provided in nursing homes or other institutional care. With services, they can remain in the community, but they may be more severely disabled than the typical clients that Senior Companion projects serve. It is important that program directors and volunteers understand the limitations of the services that they can provide (i.e., they exclude hands-on personal care, such as help with bathing, dressing, and toileting, and lifting).

Contracting Issues

Sponsors of Senior Companion projects will have to sign contracts with the state Medicaid agency or a provider agreeing to meet the state's requirements. Several issues may arise during the contracting process.

- Some states may have multiple contracting methods and service providers must be able to comply with different requirements. For example, participants in one waiver may be served through the State Unit on Aging, while the participants in a different, but similar waiver, may be served by the rehabilitation agency, each with its own contracting and service provider requirements.
- The administering agencies and case managers who oversee the services furnished to waiver participants may have preferences for particular providers. Some project directors report that although their state's system for contracting allows contracts with multiple providers who provide one type of service—such as one group of providers for home health services, another for companion services, and another for respite care—case managers may prefer providers who can provide a full array of services. Such preferences may make it difficult for Senior Companion projects to obtain a market share sufficient to support costs related to participation. In these circumstances, Senior Companion projects

may find it easier to serve waiver clients if they enter into contractual or referral arrangements with other providers. One approach is to be a subcontractor to a provider of comprehensive services, who may be interested in adding “companion services” to its array of services. These prime contractors may want a portion of the reimbursement that the Senior Companions receive to compensate them for their administrative expenses.

Recruitment and Training

Becoming a provider of HCBS waiver services may have an impact on the recruitment, training, and supervision of Senior Companion volunteers.

Another barrier in starting up as a provider for the waiver is being able to have trained companions ready to serve when the request for service comes in. It can be difficult to keep the balance of having the right number of volunteers to serve all the clients, especially in light of the federal regulations that limit who can be volunteers. Recruiting volunteers takes time and resources, and sometimes you will have clients waiting to receive services because you don't have enough volunteers to serve everyone. If you can't answer the call when a request for service comes in to your program, you will not become a reputable provider in the social service network. And the importance of having a good reputation in this service area cannot be overstated.

—John Pribyl, Lutheran Social Services
Senior Companion Program, St. Paul,
Minnesota

- In some states, the need for home and community services may be particularly high in communities with a limited number of current Senior Companion volunteers. Projects may need to consider creative strategies to attract senior volunteers from those communities. It is critical that Senior Companion projects be seen as a reliable source of services.
- With the inclusion of Senior Companions in HCBS waivers, projects may need to re-examine their training programs. In some instances, the Medicaid program may require that volunteers complete specified hours of designated training, which will need to be included in the projects' pre-service training. In other instances, projects may find that both their pre-service and ongoing training will need to add specific content—for example, the record-keeping requirements of waiver programs.

Differences When Services Are Provided Through Waivers

Senior Companions may need assistance in understanding the differences between services provided through the CNCS-funded Senior Companion projects and services provided through Medicaid waivers. When volunteers' services are provided through an HCBS waiver, they will be subject to much greater regulation and oversight than would be the case if these services were provided solely under the guidelines for the Senior Companion program. For example, the number of service hours may be capped, and services generally cannot be continued when the client enters a hospital or nursing home. In some cases, there is no coverage for travel, except to

physician appointments. Record-keeping requirements will be far more stringent in HCBS waivers. Senior Companions may have difficulty accepting these differences and may resist the regulatory requirements. Projects will need to provide appropriate training and support to volunteers so they understand the importance of these requirements.

Reimbursement

Medicaid reimbursement rates vary from state to state, but are often above the cost to most Senior Companion projects. In a sample of five states in which Senior Companion projects participate in Medicaid waivers, reimbursement rates for companion services varied from \$6.76 per hour to \$8.70 per hour in 2008. In states where the waiver program requires supervision by a registered nurse for services provided by Senior Companions and a project does not have a registered nurse on staff, the project may use the additional funding to purchase the required supervision to fully meet Medicaid's operational requirements.

Billing, Tracking Units of Services, and Service Documentation

The reimbursement rate is only part of the financial aspect of working with a Medicaid waiver program. Senior Companion projects must also develop effective systems for billing Medicaid in a timely and accurate way. While it may be possible to do the billing manually—and, in small sites, manual billing may be the only practical alternative—Medicaid programs increasingly require computerized billing systems. Some states offer software packages to vendors to facilitate automated billing. However, even when such software is available, staff will have to be trained to use it and a staff member or volunteer will need to regularly enter billing data.

Our county will not reimburse separately for travel costs. Therefore, we need to factor these costs into our rate, and some clients will have more mileage than others, especially in rural areas. Using an average based on your past and projected budgets seems to work best.

—Susan McKillips, Rock County Senior Companion Project, Janesville, Wisconsin

Medicaid documentation requirements are stringent, and, as a result, it is critical that Senior Companion volunteers carefully keep track of the service units they provide, to whom they are provided, and when. Projects may already have systems for accurate record keeping. For those that do not, putting such systems in place is essential to successfully work with Medicaid. Programs must keep accurate records of the participants seen, the days on which services are provided, and the number of service units provided during each billing period. Failure to do so will result in services not being reimbursed or in audits requiring repayment of reimbursement.

There is sometimes an issue for those companions not accustomed to dealing with paperwork. These companions may lose a sheet of paper or get confused about which day they provided services or which line the participant needs to sign. They may write an inaccurate time or use white-out to make a correction which is a fatal error for an auditor.

—Mary Kate Gill, Senior Companion Program of Waterbury, Waterbury, Connecticut

Some companions have problems keeping up with paperwork. Some may want to get ahead by having people presign and that's not permitted.

—Mary Brock, Senior Companion Project of Nevada, Sparks, Nevada

For budgetary purposes, it is essential that projects working with waiver programs have a method to carefully identify those clients whom Senior Companions serve with Medicaid funding and those whose services are financially supported through other funding sources. A process to clearly distinguish these two groups of clients is essential for accounting purposes.

Given their education levels, some Senior Companion volunteers may have difficulty with the required paperwork and documentation. Projects should plan on providing training to ensure that Medicaid's reporting requirements are met.

Verification of Medicaid Eligibility

Senior Companion projects will be reimbursed by Medicaid for services only when they are provided to individuals who are eligible for Medicaid. For that reason, projects need to regularly verify clients' eligibility for Medicaid waiver services. Many elderly persons and younger adults with disabilities, once qualified for Medicaid, tend to retain their eligibility over time. However, some may lose eligibility because of increased earnings or accumulation of financial assets above the eligibility maximum; however, they may regain Medicaid coverage when they again meet income and asset requirements.

Employees Versus Volunteers

A key component of Senior Companion projects is that the companions are considered "volunteers" rather than "employees," despite the fact that they receive a small stipend for their time. As a result, issues of minimum wage, workers' compensation, overtime and other elements of the Federal Labor Standards Act do not apply. Senior Companion project directors will need to explain this distinction to Medicaid staff. Being a Senior Companion is an opportunity to serve the community, and the small stipend helps to remove barriers for low-income people to serve.

Chapter 8

Tips From Senior Corps Project Directors Who Have Worked With Medicaid

Senior Corps project directors who have successfully worked with Medicaid have advice to share about their experience. A list of Senior Companion project directors who have agreed to provide advice to other project directors can be found in *Appendix VI*. These experts emphasize the importance of initiative on the part of project directors and support on the part of sponsoring organizations.

Make Personal Connections

Developing a good relationship with the Medicaid agency, marketing yourself to them, and making sure that they have the information about what...Senior Companions can do for them are the important components—these three elements are the keys....You have to prove to them that you have a viable service that can play an important role in serving those elderly folks who want to stay living in their own home for as long as possible.

—Dwight Rasmussen, Salt Lake County Senior Companion Project, Salt Lake City, Utah

No matter what the strategy, personal relationships are critical to success in getting Senior Companion services added to a Medicaid HCBS waiver program. Once the important agency or agencies are identified, the key questions are: Who should you contact? Does someone on the project's staff, the staff of the sponsor, the sponsor's board, or the project's Advisory Council know someone who can help? For example, does a staff member know someone who works with the Department of Aging, Health Services, or Social Services? Ongoing networking is necessary—contacting someone who knows someone who knows someone. It is through networking that projects can make key connections.

Get in the Door and Find Your Way to Decision-Makers

Personal connections provide the critical “foot in the door.” Cultivation of relationships is essential as is ongoing communication with key decision makers and ensuring that they recognize the capacity of Senior Companions to provide high-quality and cost-effective services.

Anticipate a Long Process

The process of amending an HCBS waiver to add a service is highly technical, involves many details, and takes many steps. If the HCBS waiver you want to amend will not be renewed for 2 to 3 years, it is important to have a short- and long-term strategy. Find out what will be needed in the following year and do the legwork early. Keep in touch with your key contacts on a regular

basis to ensure that you are on the right track. Do not assume a rapid decision-making process or make any financial commitments based on assumptions about what will happen and when it will happen.

Don't Take "No" for an Answer

Senior Corps project directors who have pioneered working with Medicaid waivers frequently report that the initial response to proposals to include Senior Companion services in waivers is often “not interested” or “can’t do it.” Opinions change, however, as do the people in decision-making positions and an initial “no” can often be overcome. One project director, for example, found that the Medicaid Commissioner in her state had little, if any, interest in working with the Senior Companion program. When this official was replaced, the new commissioner was much more open to the idea. Although it was not all clear sailing under the new Commissioner, the project director was able to move her proposal forward with the new commissioner.

Be Prepared for Objections

It is not unusual for projects to encounter objections to including services provided by Senior Companions in an HCBS waiver, some of which may result from a lack of understanding of the Senior Companion program. Educating decision-makers about the program and the value of its services can resolve these objections in many instances.

Be Flexible and Creative

Flexibility and creativity are essential when working with Medicaid waivers. In the words of one project director, “Don’t get fixed on a particular way to do things.” Successful work with Medicaid waivers sometimes involves finding creative ways to deliver Senior Companion services.

Flexibility and creativity also may be required because of changes in the political or administrative environment. For example, one project director described how the legislature in her state changed the administering agency for the HCBS waiver program, requiring her to forge new relationships, educate new decision makers, and find effective ways of communicating with a new agency that already had established relationships with other providers.

Start Small

Starting small can benefit Senior Companion projects in two ways. First, starting small geographically allows the Senior Companion project to refine its operational capacity to provide Medicaid services. It can “fine tune” its administrative and fiscal capabilities on a small scale

prior to taking responsibility for providing Medicaid services to larger populations or across a broader geographical area. Starting small also allows the project to establish a base of “success” on which it can build and market itself.

It is important to stay in contact with the case managers....We stay in contact by phone calls and quarterly meetings (mostly by phone). We call case managers to let them know if we have companions available, or if there is a concern about a client, and just to show that we appreciate all they are doing. Sometimes case managers have to make another assessment because of our concerns.

—Carla Boswell, Southwestern Illinois College –
Programs and Services for Older Persons,
Belleville, Illinois

Starting small can also mean beginning a relationship with Medicaid waiver programs through a single project, rather than attempting to bring all projects in the state into a waiver program simultaneously. In some states, a single project may have the administrative and volunteer capacity to step forward as a provider, and a state Medicaid agency may prefer to “see how it goes” with that project. As with starting small geographically, this type of approach provides opportunities to build experience and a base of success on which other projects may be able to build.

Maximize Internal and External Communication

When working with Medicaid waivers, it is important to establish a communication plan from the outset. Clear communication is needed between the Senior Companion project staff and the volunteer stations, between the staff and volunteers who provide the services, and between volunteers and the staff who manage the program’s finances including billing. Everyone in the program needs to understand their own and others’ responsibilities for making the program work effectively. Similarly, it is important to stay in touch with Medicaid-funded case managers and other state officials to learn about new procedures, policies, and requirements.

Be Aware of Trends in the State That Might Affect Waiver Programs

HCBS waivers can be affected by a variety of developments. It is important to monitor any significant changes taking place in the Medicaid program. Four trends are noteworthy:

- A major goal of almost all Medicaid agencies is to achieve a better balance in their long-term care system by increasing use of home and community services and decreasing the use of nursing homes. Adding services provided by Senior Companion projects is philosophically consistent with that goal.
- CMS is increasingly focusing on the quality assurance systems of Medicaid HCBS waivers and increasing scrutiny of waiver applications to make sure that they comply

with the required quality assurances.

- Some states are interested in using managed care in the delivery of Medicaid long-term care services, although the extent of interest in managed care has varied from state to state.
- States must balance their budgets annually. In times of economic downturns, states may find that their Medicaid expenditures increase quickly while revenues do not. In that environment, it will be difficult to expand services unless Senior Companion projects can successfully make the case that adding an additional service will be budget neutral or decrease costs.

Conclusion

Medicaid Home and Community-based Services (HCBS) waivers can be an important source of supplemental revenue for Senior Companion projects. The waivers can also provide more opportunities for volunteers to work with individuals who need their services. While some HCBS waivers cover services provided by Senior Companion projects, many do not. When HCBS waivers do not cover or include companion services, project directors will have to work with Medicaid agencies to amend the waiver to include them.

Because Medicaid is a complex program with many regulatory requirements, Senior Companion project directors must carefully think through the program requirements to determine if participation makes sense. As noted, there may be issues with training requirements, record keeping, reimbursement, and billing. This manual provides project directors with concrete information that will help ensure successful participation in Medicaid waiver programs.

References

- Eiken, S., and Burwell, B. (2007). *Medicaid HCBS Waiver Expenditures, FY 2001 through FY 2006*. Cambridge, MA: Thomson Healthcare.
- Kitchener, M., Ng, T., Harrington, C., and O'Malley, M. (2007). *Medicaid Home and Community-based Service Programs: Data Update*. Washington, DC: Henry J. Kaiser Family Foundation. Available at <http://www.kff.org/medicaid/upload/7720.pdf>.

Appendix I: Senior Corps Grantees and Medicaid Waiver Contracts Reported in 2008³

California

- PASSAGES Senior Companion Program (SCP) of the CSU Chico Research Foundation provided eight Senior Companions to serve eight clients with \$2,714.80 in Medicaid Waiver funds.

Connecticut

- SCP of Waterbury, sponsored by New Opportunities, Inc., assigned 19 Senior Companions to 25 adults under a Medicaid waiver contract valued at \$33,000.

Illinois

- SCP of the Belleville Area, sponsored by Southwestern Illinois College, assigned 52 Senior Companions to serve 69 clients under a Medicaid Waiver valued at \$59,000.

Iowa

- SCP of Siouxland assigned 35 Senior Companions to 43 clients under a Medicaid waiver contract valued at \$48,396.
- SCP of Rock Valley Rotary assigned 29 Senior Companions to 11 clients under a Medicaid waiver contract valued at \$4,081.25.
- SCP of Waterloo, sponsored by Hawkeye Community College, assigned 33 Senior Companions to 35 clients under a Medicaid waiver contract valued at \$84,485.
- SCP of Visiting Nurses Services assigned 30 Senior Companions to 77 clients under a Medicaid waiver contract valued at \$27,027.

Minnesota

- SCP statewide, sponsored by Lutheran Social Services of Minnesota, assigned 169 Senior Companions to 410 clients under a Medicaid waiver contract valued at \$413,595.
- SCP of Northwestern Minnesota, sponsored by Tri-Valley Opportunity Council, assigned 19 Senior Companions to 74 clients under a Medicaid waiver contract valued at \$43,329.

Medicaid Waiver Contracts			
State	#SCP Volunteers	# Clients	Funds
1. California	8	8	\$2,714.80
2. Connecticut	19	25	\$33,000.00
3. Illinois	52	69	\$59,000.00
4. Iowa	117	166	\$163,989.25
5. Michigan	35	260	\$7,140.00
6. Minnesota	188	484	\$456,924.00
7. Nevada	133	267	\$160,000.00
8. Pennsylvania	27	33	\$49,806.00
9. South Carolina	15	16	\$46,424.00
10. Utah	43	52	\$36,201.00
11. Wisconsin	24	22	\$48,837.00
Totals	661	1,402	\$1,064,036.05
Total Grantees: 21			

³ Source: Corporation for National and Community Service, State Highlight Reports, Reported in 2008 for 2007.

Nevada

- SCP of Las Vegas, sponsored by Catholic Charities of southern Nevada, assigned 20 Senior Companions to 116 clients under a Medicaid waiver contract valued at \$60,000.
- SCP of Nevada, sponsored by the Elvirita Lewis Forum, assigned 113 Senior Companions to 151 clients under a Medicaid waiver contract valued at \$100,000

Pennsylvania

- SCP of Philadelphia, sponsored by the Philadelphia Corporation for Aging, assigned 27 Senior Companions to 33 clients under a Medicaid waiver contract valued at \$49,806.

South Carolina

- SCP of Midlands, sponsored by Senior Resources, Inc., assigned five Senior Companions to five clients under a Medicaid waiver contract valued at \$13,454.
- SCP of Orangeburg-Calhoun-Allendale-Bamberg Counties, sponsored by OCAB Community Action Agency, assigned 9 Senior Companions to 10 clients under a Medicaid waiver contract valued at \$28,392.
- Chester County SCP, sponsored by Chester County Senior Services, Inc. assigned one Senior Companion to one client under a Medicaid waiver contract valued at \$4,578.

Utah

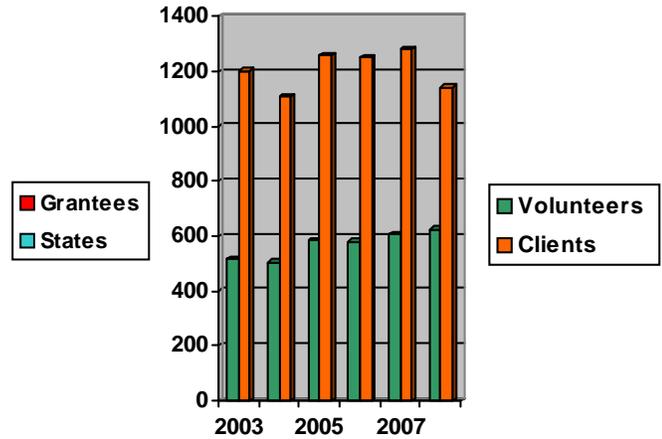
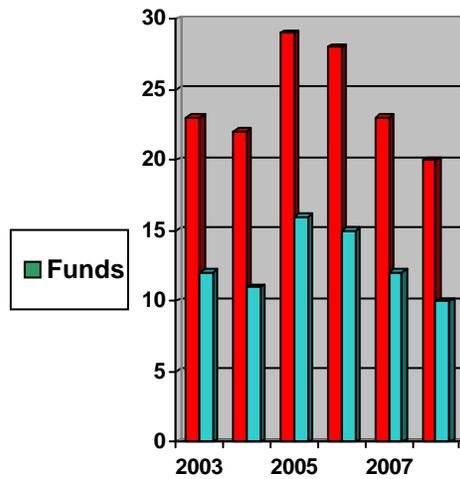
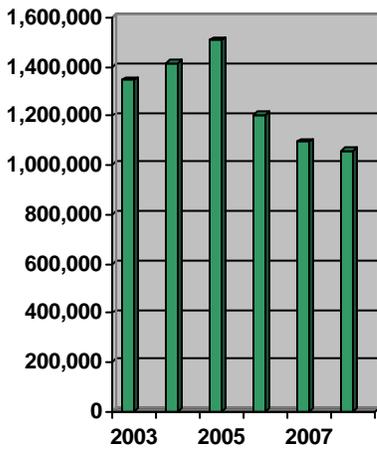
- Five County SCP, sponsored by Five County Association of Governments, assigned 7 Senior Companions to 11 clients under a Medicaid waiver contract valued at \$11,214.
- Salt Lake County SCP, sponsored by Salt Lake County Aging Services, assigned 14 Senior Companions to 16 clients under a Medicaid waiver contract valued at \$14,244.
- Utah County SCP, sponsored by the Utah County Commission, assigned 14 Senior Companions to 17 clients under a Medicaid waiver contract valued at \$4,271.
- Cache County SCP, sponsored by Bear River Association of Governments, assigned eight Senior Companions to eight clients under a Medicaid waiver contract valued at \$6,472.

Wisconsin

- SCP of Rock County, sponsored by Senior Services of Rock County, Inc., assigned 24 Senior Companions to 22 clients under a Medicaid waiver contract valued at \$48,837.

Appendix II:
Senior Companion Program and Medicaid Waiver Contracts
Year-to-Year Comparison 2003–2008
 Compiled September 2008

Element	Year Reported					
	2003 Total	2004 Total	2005 Total	2006 Total	2007 Total	2008 Total
1. Number of states	12	11	16	15	12	10
2. Number of grantees	23	22	29	28	23	20
3. Number of Senior Companions	515	506	584	580	630	626
4. Number of clients served	1,202	1,107	1,257	1,253	1,309	1,142
5. Funds	\$1,346,536	\$1,412,584	\$1,507,593	\$1,206,717	\$1,095,173	\$1,056,896



Appendix III: Other Options for Medicaid and State-funded Financing for Senior Companion Projects

There are at least three other possible sources of government funding for Senior Companion projects:

- New options for Medicaid under the Deficit Reduction Act of 2005: Home and Community-based Services
- New options for Medicaid under the Deficit Reduction Act of 2005: Cash and Counseling
- State-Funded Home and Community-based Care

New Options for Medicaid Under the Deficit Reduction Act of 2005: Home and Community-based Services

Under Section 6086 of the 2005 Deficit Reduction Act, Congress established that states could provide home and community-based services as an optional Medicaid benefit under their Medicaid State Plan. Beginning in January 2007, states were allowed to offer some of the home and community-based services that were previously permitted only by waiver under Section 1915(c)(4)(B) of the Social Security Act. Payment for room and board, however, was not allowed.

General Options and Requirements for States:

- States are not required to demonstrate that providing the benefit will cost the federal government less than placing persons in institutional care.
- States may offer the benefit without determining that, in the absence of the benefit, a person would require the level of care provided in a hospital, nursing home, or intermediate care facility for people with mental retardation.
- States may offer the benefit only in certain parts of the state; they are not required to offer it statewide.
- States may limit the number of persons they enroll.
- States may maintain waiting lists for the benefit.

Eligibility:

- Only persons whose income does not exceed 150 percent of the federal poverty level are eligible to receive the benefit.
- States that adopt the benefit must establish needs-based eligibility criteria for the benefit which is less stringent than the needs-based eligibility for institutional services. If the needs based-eligibility criteria for institutional services become more stringent because of this requirement, persons receiving institutional services or waiver services at the time the state adopts the benefit must continue to be eligible under the previous standards until they are discharged from the institution or waiver service, or until they no longer qualify for Medicaid.

- States may change the eligibility criteria for the benefit if enrollment in the benefit exceeds the numbers of enrollees expected. If a state does change the eligibility criteria, it must provide 60 days notice of the change and persons already receiving the benefit:
 - Must continue to be eligible to receive it for at least 12 months from the time they began to receive services, and
 - Must then be eligible for institutional services under criteria no more stringent than the criteria the state used before the state began the benefit.

Implementation:

- States are required to provide participants with an individualized assessment and a written plan of care.
- States may allow self-direction of services under which the participant or an authorized representative directs or controls the amount, duration, scope, provider, and location of services, with a service plan that
 - Ensures the rights of the individual;
 - Defines the roles of representatives and family members; and
 - Addresses risk management, budgeting, and quality assurance.

Additional Information:

- Crowley, J. (2006) Issue Paper: Medicaid Long-Term Services Reforms in the Deficit Reduction Act. Kaiser Commission on Medicaid and the Uninsured. <http://www.kff.org/medicaid/upload/7486.pdf>
- Disability Policy Collaboration (2006) *The Deficit Reduction Act of 2005, P.L. 109-171*. http://www.ucp.org/uploads/Deficit_Reduction_Act_of_2005_March_06.doc.
- Library of Congress. *Deficit Reduction Act of 2005. Sec. 6086. Expanded Access to Home and Community-based Services for the Elderly and Disabled*. <http://thomas.loc.gov/cgi-bin/query/F?c109:5:./temp/~c109hK9vbM:e372415>:
- Tritz, K., Tilson, S., Stone, J., Peterson, C., O’Sullivan, J., Morgan, P., Herz, E., Jean Hearne, J., Hahn, J., Grady, A., Chaikind, H., Baumrucker, E. (2006) *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*. Congressional Research Service, Library of Congress. <http://digital.library.unt.edu/govdocs/crs/permalink/meta-crs-9230:1>

New Options for Medicaid Under the Deficit Reduction Act of 2005: Cash and Counseling

In Section 6087 of the 2005 Deficit Reduction Act, Congress established that states could adopt the “cash and counseling” model to purchase services for some beneficiaries as an optional Medicaid benefit under the State Plan. Beginning in January 2007, states were allowed to use the model to pay for part or all of the cost of self-directed personal assistance services in certain circumstances. Payment for room and board, however, was not allowed.

General Options and Requirements for States:

- States may offer the benefit only in certain parts of the state; they are not required to offer it statewide.
- States may limit access to the benefit to certain populations.
- States may limit the numbers of persons receiving the benefit.
- States may employ a financial management entity to make payments, track costs, and make reports for the program as a Medicaid administrative expense.
- States must evaluate persons who are entitled to medical assistance for personal care, may require it, and may be eligible for it.
- States must inform persons who are found likely to require personal care of the Medicaid programs available to provide it.
- States must provide a system of assessment and counseling to ensure that participants are able to manage their budgets.

Eligibility:

- Persons must qualify for Medicaid personal care and related services under the State Plan or for home and community-based services under a waiver to participate in the benefit
- Persons living in a home or property that is owned, operated, or controlled by a service provider who is not related by blood or marriage are not eligible for the benefit.

Implementation:

- A written plan of services is required, including the following:
 - Control over the budget, planning, and purchase of services by the participant or an authorized representative, including the amount, duration, scope, provider, and location of services.
 - An assessment of the needs, strengths, and preferences of the participant.
 - Supports for the participant's capacity to engage in community life, respects the participant's choices and abilities, and involves family and professional support as desired by the participant.
- A budget is required; it must be a public document based on reliable cost data and calculated based on the expected cost of services if they were not self-directed. The budget cannot restrict access to other medical services provided under the plan but not included in the budget.
- Participants may hire, fire, supervise, and manage service providers.
- States may allow any capable individuals to serve as paid service providers, including legally responsible relatives.
- States may allow participants to use budgeted funds for items that increase independence or substitute for human assistance.
- States must put in place safeguards for the health and welfare of participants, including risk management and quality assurance.
- States must ensure financial accountability for funds expended under the benefit.

Additional Information:

- Crowley, J. (2006) Issue Paper: Medicaid Long-Term Services Reforms in the Deficit Reduction Act. Kaiser Commission on Medicaid and the Uninsured. <http://www.kff.org/medicaid/upload/7486.pdf>
- Disability Policy Collaboration (2006) *The Deficit Reduction Act of 2005, P.L. 109-171*. http://www.ucp.org/uploads/Deficit_Reduction_Act_of_2005_March_06.doc.
- Library of Congress. *Deficit Reduction Act of 2005. Sec. 6087. Optional Choice of Self-Directed personal Assistance Services (Cash and Counseling)*. <http://thomas.loc.gov/cgi-bin/query/F?c109:5:./temp/~c109hK9vbM:e372415>:
- Tritz, K., Tilson, S., Stone, J., Peterson, C., O'Sullivan, J., Morgan, P., Herz, E., Jean Hearne, J., Hahn, J., Grady, A., Chaikind, H., Baumrucker, E. (2006) *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*. Congressional Research Service, Library of Congress. <http://digital.library.unt.edu/govdocs/crs/permalink/meta-crs-9230:1>

State-funded Home and Community-based Care

While Medicaid state plans and waivers are the largest spenders for home and community-based care services, most states also have at least one state-only funded home and community-based services program. A 2007 study found state-funded home and community-based programs in 47 states and the District of Columbia. Although small compared to Medicaid, these programs are not insignificant, with one survey reporting total expenditures of \$1.4 billion in 2002. Some states have state-only funded home and community-based programs providing a range of services.

State-funded home and community-based service programs are often designed to complement or supplement the state's Medicaid services. In some cases the programs can provide support for people waiting for Medicaid services; in other cases the programs serve those who do not meet Medicaid functional or financial eligibility criteria. A smaller number of state-funded programs provide services that supplement those provided by Medicaid to participants.

While state-funded home and community-based programs vary from state to state, there are several areas of commonality in their operations:

- A large majority of state-funded home and community-based programs provide homemaker support, adult day or respite services, personal care assistance, care coordination, transportation, home-delivered meals, home repairs and modifications, and chore services. Some programs provide one service, but many programs provide multiple services. The programs serve populations ranging from a few dozen to more than 200,000.
- Financial support for most state-funded home and community-based programs comes from state general revenues. A number of states also use funds from specific sources,

including tobacco taxes, casino revenue, state lottery income, and revenue from sales of unclaimed property.

- Most state-funded home and community-based programs serve people aged 60 and older, although a few serve only those aged 65 and older. Most programs do not have a financial eligibility requirement. Some programs have additional criteria for eligibility, including Alzheimer's disease and risk of nursing home placement, or target those in minority communities, in rural areas, or with low incomes.
- Participants in state-funded home and community-based programs tend to be older than the minimum age for participation; available data indicate that they tend to be aged 75 or older. The majority of participants are women, and they often live alone.
- States use three main strategies to control the cost of these programs. The most common strategy is cost-sharing, in which participants are required to make a copayment to receive a service. Those programs using this strategy generally employ a sliding scale based on the participant's income. Another, less common, strategy is to place a limit on the amount of service a participant may receive, such as a maximum number of visits or hours of service. States may also place a cap on the total expenditures for services to one participant during a particular month or quarter.

Additional Information:

- Kitchener, M., Wong, A., Willmott, M., Harrington, C. (2007) *Home and Community-based Services: State-Only Funded Programs*. UCSF National Center for Personal Assistance Services. http://www.pascenter.org/state_funded/index.php
- Summer, L., Ihara, E. (2004) *State-Funded Home and Community-based Service Programs for Older People*. AARP Public Policy Institute. http://www.aarp.org/research/housing-mobility/homecare/statefunded_home_and_communitybased_service_progra.html

Appendix IV: Resources on Medicaid HCBS Waivers

Presented below is an annotated list of websites useful to Senior Companion projects interested in becoming Medicaid HCBS waiver providers

Medicaid Information From the Centers for Medicare & Medicaid Services

[Medicaid Main Page](#)

This page contains links to information about administration and policy for all aspects of the Medicaid program.

[Medicaid Eligibility Page](#)

This page contains an overview of eligibility requirements with links to specific information about eligibility and contact information for state Medicaid offices.

[Medicaid Waiver Page](#)

This page contains an overview of the waiver program and descriptions of the different types of waivers. Links on the page connect to a map and list of all state-specific Medicaid waiver and demonstration programs.

[Medicaid 1915\(c\) Home and Community-Based Waivers Page](#)

This page describes the 1915(c) waiver program, including the application process and program requirements.

[Medicaid Waiver and Demonstration Map Page](#)

This page contains a map with links to a list

of the Medicaid waivers authorized for each state, including a brief description of the program, type of waiver, the date approved, and the date implemented.

[Medicaid Waiver Application Page](#)

This page is the portal to the web-based application which states may use to request a Medicaid waiver. The waiver application form and support materials can also be downloaded. The instruction document for the waiver application includes definitions of services provided under the waivers.

[Medicaid Home and Community-Based Services Page](#)

This page describes the quality assurance program for Medicaid home and community-based services with links to quality measurement documents. A link on the page connects to reports of promising practices in home and community-based services.

[Medicaid at a Glance](#)

This booklet provides an overview of Medicaid services, including a listing of services offered by each state.

Information About Medicaid Implementation by the States

Center for Personal Assistance Services [State Medicaid Waiver Contact Information and Descriptions Page](#)

This page contains a map with links to contact information and descriptions for

each state's home and community-based Medicaid waivers.

[Medicaid Waiver Data Page](#)

This page contains a map with links to data

about participants and expenditures for each state's Medicaid home and community-based waivers.

Henry J. Kaiser Family Foundation
[State Medicaid Facts Sheet Page](#)

This page provides fact sheets for each state based on the latest data in the Kaiser Foundation database of state health information. The fact sheets include information about Medicaid enrollment and eligibility in each state, along with demographic and health insurance data.

[Medicaid Benefits by State Online Database](#)

This page contains a state-by-state listing of Medicaid covered services with information including coverage, approval requirements, and reimbursement methodology.

[Home and Community-Based Waiver Services Database](#)

This page contains a state by state listing of Medicaid home and community-based

waivers with information about coverage, approval requirements, and reimbursement methodology.

[Waiting Lists for Medicaid 1915\(c\) Home and Community-Based \(HCBS\) Waivers, 2006, Page](#)

This page lists the number of persons on waiting lists for services from each type of Medicaid waiver in each of the states.

National Association of State Medicaid Directors

[Links page](#)

This page contains a map with links to the websites for the state Medicaid agencies.

[State Medicaid Director Letters page](#)

This page contains links to the letters from the Centers for Medicare & Medicaid Services to State Medicaid Directors since 2004, transmitting information and guidance.

Further Information About Medicaid

AARP

[Policy and Research – Medicaid Page](#)

This page contains links to all of AARP's research reports related to Medicaid.

[Medicaid Eligibility Policy for Aged, Blind, and Disabled Beneficiaries](#)

This AARP report analyzes state policies on Medicaid eligibility for aged, blind, and disabled population.

Henry J. Kaiser Family Foundation

[Medicaid and SCHIP Page](#)

This page contains links to all the foundation's reports and data about Medicaid.

[Medicaid Home and Community-Based Service Programs: Data Update](#)

This report provides an analysis of the most recent available data for enrollment and expenditures for Medicaid waiver services.

National Academy for State Health Policy
[State Health Policy Publications Strengthening Medicaid](#)

This page has links to Academy reports analyzing Medicaid initiatives and policy options.

**Office of the Assistant Secretary for
Planning and Evaluation, U.S.
Department of Health and Human
Services**

[Medicaid Page](#)

This page contains links to all the resources on Medicaid developed by this office.

[Federal Medical Assistance Percentages](#)

This site provides links to reports listing the percentage of federal matching funds for Medicaid expenditures by each state.

[Understanding Medicaid Home and
Community Services: A Primer](#)

This report describes the Medicaid program of home and community services and discusses options for expanding access to supports for people of all ages with disabilities.

**U. S. House of Representatives,
Committee on Ways and Means**
[Green Book – Background Material and
Data on Programs, Medicaid Page](#)

The Medicaid section of the Green Book provides background information and statistical data about Medicaid. The latest edition was issued in March 2004.

Information About Medicaid Managed Care

Henry J. Kaiser Family Foundation
[Enabling Services: A Profile of Medicaid
Managed Care Organizations](#)

This report provides basic statistics on Medicaid managed care organizations providing enabling services—transportation, translation, education, and case management. The report also discusses the extent of variation across plans.

National Academy for State Health Policy
[Medicaid Managed Care](#)

This Academy report examines Medicaid managed care and tracks changes and trends

in Medicaid managed care between 1990 and 2002.

**Examples of Medicaid Managed Care
Plans**

[Minnesota](#)

This site describes the Minnesota Senior Health Options plan.

[Texas](#)

This link describes the Star+Plus plan.

[Wisconsin](#)

This site describes the Family Care program.

General Information About Home and Community-based Services

Center for Personal Assistance Services
[Index of State Pages](#)

This page contains links to multiple types of state-level data and reference materials relating to home and community-based services. Although the website emphasizes workforce issues, the data and many of the reports address consumer concerns.

[Clearinghouse for the Community Living
Exchange Collaborative](#)

This website provides access to a wide range of resources for home and community-based services produced by states, federal agencies, and research organizations. Resources on the site can be sorted and searched by state, topic, type of resource, or source.

National Association of State Units on

Aging

[Technical Assistance and Resources Page](#)

This website contains training materials for aging and cultural competency and links to resources for providing home and community-based services to diverse populations.

General Information About Long-Term Care

AARP

[Across the States 2006: Profiles of Long-Term Care and Independent Living](#)

This report provides a national overview and state-specific reports of long-term care, including Medicaid services, resources, and payment rates. The web page also includes links to other AARP resources about long-term care.

National Conference of State Legislatures

[Long-Term Care Page](#)

This page contains links to state long-term care legislation since 2001 and information about long-term care policy issues.

National Clearinghouse for Long-Term Care Information

[Home page](#)

This site provides information about long-term care including services, definitions, and financing.

Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

[Office of Disability, Aging, and Long-Term Care Home Page](#)

This site provides links to research reports by this office examining a range of subjects, including home and community-based long-term care.

U.S. Agency for Healthcare Research and Quality

[Long-Term Care Page](#)

This site provides links to research reports from this agency examining a range of subjects related to long-term care, including home and community-based long-term care.

Appendix V: “Companion Services” Examples from Minnesota and Utah

Examples of Service Definitions

Generally, the types of services that can be provided by Senior Companions are likely to fall within the service categories called “Companion Services,” “and “Respite Care.” Which type of service(s) to pursue for inclusion in a waiver will be an important part of the discussions that project directors have with the administering agency or the Medicaid agency. The following examples of definitions of these services, taken from approved HCBS waivers, can be used in such discussions.

Minnesota: Adult Companion Services	
DEFINITION	Nonmedical care, assistance, or supervision and socialization provided to an adult in accordance with a therapeutic goal in the community support plan and not purely diversional in nature.
COVERED SERVICES	The goals of adult companion services are directed at companionship, assistance, or supervision of the recipient in the home or community. Adult companion services may include the assistance or supervision of the recipient with such tasks as <ul style="list-style-type: none"> • meal preparation, • laundry, • shopping, and • light housekeeping tasks incidental to care and supervision.
NONCOVERED SERVICES	Adult Companion Services do not include <ul style="list-style-type: none"> • hands-on nursing care, or • activities that are not directed at a goal.
PROVIDER STANDARDS AND QUALIFICATIONS	The local lead agency is responsible to ensure that whoever provides services (individual and/or agency) meets the following minimum standards and <ul style="list-style-type: none"> • is able to read and write; • is able to follow written and oral instruction; • has had experience and/or training in homemaking skills and/or in care of recipients with handicapping conditions; • is in good physical and mental health; • has the ability to converse effectively on the telephone; • has the ability to work with intermittent supervision;

Minnesota: Adult Companion Services

PROVIDER STANDARDS AND
QUALIFICATIONS
(CONTINUED)

- has the ability to manage emergency and/or crisis situations and report them to the lead agency;
- is able to understand, respect and maintain confidentiality in regard to the details of any circumstances surrounding the recipient;
- any person related to the recipient by blood, marriage, or adoption cannot be paid for providing this service;
- an individual may be required to pass on a job-related physical examination before starting to provide services;
- any person related to the recipient by blood, marriage, or adoption cannot be paid for providing this service; and
- an individual may be required to pass a job-related physical examination before starting to provide services.

Source: Minnesota Health Care Plan Provider Manual

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelecti onMethod=LatestReleased&dDocName=id_056766.

Utah: Adult Companion Services

DEFINITION	<p>Companion (COM) is one-on-one hourly and daily nonmedical care, supervision, and socialization services for functionally impaired adults and children. Companions may assist or supervise the person with such tasks as meal preparation, laundry, and shopping, but do not perform these services as discrete services. Companions do not provide hands-on nursing care. Companions may perform light housekeeping tasks that are incidental to the care and supervision of the person. COM is provided in accordance with a therapeutic goal in the person’s plan as is not purely diversional in nature.</p>
COVERED SERVICES	<ul style="list-style-type: none"> • Personal Assistance (PAC) • Persons are excluded from receiving the following services and COM: (Cannot bill for COM and the codes listed above and below in bold.) • Adult Foster Care (AFC) • Host Home Support (HHS) • Professional Parent Supports (PPS) • Residential Habilitation Support (previous Community Living Support) (RHS) • Residential Habilitation Intensive Support (previous Community Living Intensive Support) (RHI) • Persons who receive COM may not bill for Supported Living, Day Support, or Supported Employment services that occur during the same hours of the day. • COM services are intended for those participating in the Provider-based method, only.
POPULATION SERVED	<p>The Contractor shall serve people currently receiving services from DHS/DSPD with mental retardation and related conditions, and adults aged 18 and older with acquired brain injury, as defined in Utah Administrative Code R539-1 (http://rules.utah.gov/publicat/code/r539/r539.htm).</p>
PROVIDER STANDARDS AND QUALIFICATIONS	<ul style="list-style-type: none"> • Contractor shall have all applicable licenses or certifications as prescribed in Utah Administrative Code R501 (http://rules.utah.gov/publicat/code/r501/r501.htm) to operate and provide the particular type of services being offered and comply with insurance requirements and any local ordinances or permits. • Contractor shall be enrolled as an approved Medicaid Provider with the Utah Department of Health and agree to allow DHS/DSPD to bill Medicaid on its behalf for covered Medicaid services included in the rate paid by DHS/DSPD to the Contractor. Contractor shall also agree to participate in any DHS/DSPD-provided Medicaid training. • Contractor shall be under DHS/DPSD contract to provide COM and

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	<p>certified by DSPD.</p> <ul style="list-style-type: none"> • Contractor shall provide emergency procedures for fire and other disasters. • Contractor shall disclose room and board charges and food stamps or other income not originating with DHS/DSPD. • Contractor shall develop and implement a policy to govern the handling, storage, disposal and theft prevention of medication. • Contractor shall develop and implement a procedure regarding the nutrition of the person.
<p>STAFF QUALIFICATIONS</p>	<ul style="list-style-type: none"> • Staff shall demonstrate competency in providing COM services, as determined by the Contractor, in addition, all applicable education, and training shall be completed before performing any work for persons without supervision. • COM staff shall be trained in the Staff Training Requirements as outlined in applicable General Requirements, Home and Community-based Waiver, rule, statute, and contract. • Staff shall pass a Bureau of Criminal Identification (BCI) background check through the DHS, Office of Licensing and have a record of the BCI results in the staff record, http://rules.utah.gov/publicat/code/r501/r501-14.htm. • COM staff shall be at least 18 years of age.
<p>TRAINING REQUIREMENTS</p>	<p>All direct care and direct care supervisory staff shall receive specific staff training that prepares them to complete the critical job functions for this service and orients them to the person being supported by this service. Training shall be conducted by qualified trainers with professional experience and knowledge in providing services and supports to persons with mental retardation, related conditions, and brain injury. Staff shall complete and achieve competency in specific training areas 1 through 8 within 30 days of employment or before working unsupervised with a person. Staff shall complete and achieve competency in training areas 9 through 12 within 6 months of employment.</p>
<p>TRAINING AREA 1</p>	<p>Medication Competency</p> <ol style="list-style-type: none"> 1. Identification of common medications, their effects, purpose and side effects. 2. Identification of medications and medication side effects specific to the person. 3. Recording and documentation of self-administration of medications. 4. Training on commonly used medications including the reason and circumstance for administration, dose, and scheduling.
<p>TRAINING AREA 2</p>	<p>Recognition of illness or symptoms of health deterioration specific to the person.</p>
<p>TRAINING AREA 3</p>	<p>Dietary issues specific to the person.</p>

Utah: Adult Companion Services	
TRAINING AREA 4	Critical health care issues specific to the person.
TRAINING AREA 5	Swallowing and eating difficulties specific to the person.
TRAINING AREA 6	Principles of age appropriate community inclusion and natural support development specific to the person.
TRAINING AREA 7	Preferences and nonnegotiable routines specific to the person.
TRAINING AREA 8	Significant functional limitations and disabling conditions specific to the person.
TRAINING AREA 9	Key elements of the Americans with Disabilities Act.
TRAINING AREA 10	Person-centered assessment and plan development.
TRAINING AREA 11	How to develop and support the person's preferred recreational and leisure activities.
TRAINING AREA 12	<p>Contractor and Contractor's staff providing Acquired Brain Injury services shall demonstrate competence or awareness in the following areas:</p> <ol style="list-style-type: none"> a. Effects of brain injuries on behavior, b. Transitioning from hospitals to community support programs including available resources, c. Functional impact of brain changing, d. Health and medication, e. Role of the direct care staff relating to the treatment and rehabilitation process, f. Treatment plan and behavioral supports, and g. Awareness of the family's perspective on the brain injury.
DIRECT SERVICE REQUIREMENTS	<p>A. Person-Centered Planning: Contractor staff shall participate in and comply with the requirements of the DHS/DSPD Person-Centered Planning Process in providing services.</p> <ol style="list-style-type: none"> 1. The Contractor is responsible for implementing the applicable portion of the Individual Support Plan's Action Plan (ISP/AP). These may include a Behavior Support Plan, Psychotropic Med Plan, Staff Instruction sheet, and data collection and/or Task Analysis sheet for skill training or other support. 2. Once the ISP/AP has been developed, the Contractor shall orient the person to that part of the plan that is applicable to the Contractor and ensure the person is involved in its implementation. 3. The Contractor shall develop and implement Support Strategies for the person. Contractor shall submit Support Strategies and Monthly Summaries to DHS/DSPD. 4. The Contractor, as a member of the person's Team, is required to assist in assessments and meet at least annually (within 12 months of the last Person-Centered Process meeting) to review the person's service/support requirements and to make adjustments as necessary based on the person's needs. However, it may meet more often as determined by the person or

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	<p>other members of the team.</p> <p>B. Person’s Personal Funds</p> <ol style="list-style-type: none"> 1. In the event of an emergency situation, a Contractor may write a check to the person or the person may borrow money from the Contractor. The person’s support team shall be notified and grant approval of the Contractor’s actions. The Contractor’s staff shall document the emergency and the person’s support team approval and maintain this documentation in the person’s record. The Contractor shall have policies and procedures in place to make sure a person does not continuously owe the Contractor money due to emergency situations. 2. A person shall not give cash to or make purchases from the Contractor or Contractor’s staff. A person shall not write checks to the Contractor’s staff. Only in cases of emergency, may a person write a check to repay a loan made by the Contractor. Contractor shall ensure the person has adequate access to personal finances to cover anticipated expenditures. The exceptions to persons making payments to the Contractor are as follows: (a) reimbursement to the Contractor for destruction of property by the person, if approved by the team, and allowable by contract; and (b) room and board charges. 3. The Contractor’s staff shall not loan or give money to a person. The Contractor shall not loan or give money to a person except in case of an emergency. A person shall not loan or give money to the Contractor’s staff or the Contractor itself. 4. Belongings with a purchase price or value of \$50.00 or more shall be inventoried. The inventory shall also include other items of significance to the person, which may cost less than \$50.00. The inventory shall be maintained on an ongoing basis and reviewed annually. Discarded items shall be deleted from the inventory list. Documentation of the reason for the deletion of an item shall be maintained and shall require the signature of the person/representative and one Contractor staff or two Contractor staff if the person/representative is not available. Personal possessions shall be released to the person/representative whenever the person moves.
<p>HEALTH AND SAFETY REQUIREMENTS</p>	<ol style="list-style-type: none"> 1. Contractor shall ensure that persons receive training, opportunities to seek and obtain routine and acute medical, dental, psychiatric, or other health-related services, as outlined in the person’s ISP, as allowed by the person’s Medicaid and insurance plans. 2. Contractor staff shall ensure persons receive training and assistance to <ol style="list-style-type: none"> a. identify primary health care practitioners; b. obtain dental and physical examinations;

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	<ul style="list-style-type: none"> c. safely follow physician orders; d. document the frequency, dosage, and type of medication taken; and e. know what prescribed medication is for, if the medication is the right dose, if the medication is taken properly, and know if the medication is taken according to the schedule prescribed by the person’s physician. <p>3. Medications shall be properly stored according to the person’s needs and capabilities, as determined by the team.</p> <p>4. Contractor staff shall immediately contact the appropriate medical professional to report the discovery of any prescribed medication error, including actual missed or suspected missed dosage, misadministration of medication, medication administered at the wrong time, or failure to follow laboratory survey schedule, etc.</p> <ul style="list-style-type: none"> a. Any medication errors that occur shall be documented in the person's file and reported to the Support Coordinator and Contractor Director or designee. <p>5. Contractor shall notify the Support Coordinator and person representative within 24 hours of the development of a medical issue for any person, such as illness requiring medical appointments or an emergency room visit. This does not include medical appointments for general health checkups.</p> <p>6. Any allergies the person has shall be recorded by Contractor staff in the person’s medical record and disclosed to the person’s primary physician.</p>
<p>HEALTH AND NUTRITION REQUIREMENTS</p>	<ul style="list-style-type: none"> 1. Persons shall have kitchen privileges with access to food and ingredients. Kitchen privileges may be limited if approved by the Human Rights Committee, in the interest of the person’s health. 2. Contractor staff shall assist persons in planning meals to meet basic nutritional standards, special diets, food preferences, customs, and appetites.
<p>TRANSPORTATION</p>	<ul style="list-style-type: none"> 1. Contractor shall provide incidental transportation to shopping and other community activities, based on the Contractor’s and team’s reasonable, professional judgment. 2. The Contractor shall check driver’s driving record annually and shall ensure that driver’s with problematic records are not allowed to continue providing transportation as part of this service. Contractor shall check annually that drivers providing transportation in their personal vehicles have current/adequate auto Companion Services (COM) Service Description COM insurance. Contractor shall keep documentation of this review and copies of the driver’s record and auto insurance in the employee’s file. 3. Drivers make certain that <ul style="list-style-type: none"> o Persons are not left unattended in the vehicle. o Persons use seat belts and remain seated while the vehicle is in motion.

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	<ul style="list-style-type: none"> ○ Keys are removed from the vehicle at all time when the driver is not in the driver’s seat unless the driver is actively operating a lift on vehicles that require the keys to be in the ignition to operate the lift. ○ All persons in wheelchairs use seat belts, or locking mechanisms to immobilize wheelchairs during travel. ○ Persons are transported in safety restraint seats when required by Utah State law. ○ Vehicles used for transporting persons have working door locks. Doors are locked at all times while the vehicle is moving. ○ Persons arrive safely at the scheduled time and arranged destination, that no one is left alone along the way to or from day supports even in emergency situations or when the health and safety of others may be in question. If necessary during an emergency, the driver may wait until another driver arrives to complete the transport.
ACCESS TO COMMUNITY SERVICES	Contractor shall assist the person in accessing community services and resources, including but not limited to finding housing, applying for food stamps, obtaining Social Security benefits, etc.
STAFF SUPPORT	COM is a one-to-one service with an hourly and daily rate. If a person requires more than 6 hours a day of COM then the daily rate shall be used. Actual type, frequency, and duration of direct care staff support, and other community living supports shall be defined in the person’s ISP/AP based on the person’s selected housing arrangement and assessed needs.
RATE	COM is a one-to-one service with an hourly and daily rate. Payments for COM services are not made for room and board, the cost of facility maintenance, routine upkeep, or improvement. Personal needs costs are covered through personal income such as Social Security and other income (SSA, SSI, employment).

Source: Utah Department of Human Services. (undated). *Services for People with Disabilities: Service Descriptions*. Salt Lake City, UT. http://www.dspd.utah.gov/docs/service_description/COM%2004-08.pdf.

Appendix VI: Experts to Contact for Further Information

State	Program Name	Contact	Phone	E-mail	Sponsor	Address	City	Zip
Connecticut	SCP of Waterbury	Lesley West	203-575-9799 x214	lwest@newopportunitiesinc.org	New Opportunities, Inc.	232 N Elm St.	Waterbury	06702
Florida	SCP of Miami-Dade Co.	Elizabeth Morales	786-469-4581	emorale@miamidade.gov	Metro Dade Community Action Agency	395 NW First St.	Miami	33128
Illinois	SCP of Belleville Area	Carla Boswell	618-234-4410 x7036	carla.boswell@swic.edu	SCP of Southwest Illinois College	201 North Church Street	Belleville	62220
Iowa	SCP of Waterloo	Penny Fox	319-233-6726	pfox@hawkeyecollege.edu	Hawkeye Community College	844 W 4th St.	Waterloo	50702
Michigan	St. Joseph, SCP	Camellia Pisegna	269-983-7058	camelliapisegna@areaagencyonaging.org	Region IV AAA, Inc.	2900 Lakeview	St. Joseph	49085
Minnesota	SCP of MN	John Pribyl	651-310-9444	john.pribyl@lssmn.org	Lutheran Social Service of Minnesota	590 Park Street, Suite 406	Saint Paul	55103
Minnesota	SCP of NW MN	Heidi Simmons	218-281-5832	heidi@tvoc.org	Tri-Valley Opportunity Council	102 N Broadway	Crookston	56716
Nevada	SCP of Nevada	Mary Brock	775-358-2322	brockm9146@sbcglobal.net	Elvirita Lewis Forum	406 Pyramid Way	Sparks	89431
Utah	Salt Lake County SCP	Dwight Rasmussen	801-468-2775	drasmussen@slcu.org	Salt Lake County Aging Services	2001 S State St. #S-1500	Salt Lake City	84190
Wisconsin	SCP of Rock County	Susan McKillips	608-757-5943 #2	skmckillips@seniorservicesrock.com	Senior Services of Rock County Inc.	120 N Crosby Ave.	Janesville	53547

