# Habilitation Eligibility (Non-Financial)
## LOC-003

| | | | |
|---|---|---|---|
| **Iowa Medicaid Program** | Habilitation | **Effective Date** | 01/01/2007 |
| **Revision Number** | 9 | **Last Reviewed** | 10/17/2025 |
| **Reviewed By** | Medicaid Medical Director | **Next Review** | 10/16/2026 |
| **Approved By** | Medicaid Clinical Advisory Committee | **Approved Date** | 09/05/2017 |

## Criteria

The member has a Level of Care Utilization System (LOCUS) or Child and Adolescent Level of Care Utilization System (CALOCUS) actual disposition of level one recovery maintenance and health management or higher on the most current LOCUS/CALOCUS assessment completed within the past 30 days.

Medicaid members must meet at least **ONE** of the risk factors in Section I; **AND** must meet at least **TWO** of the need for assistance criteria in Section II on a continuing or intermittent basis for at least 12 months.

## Section I – Risk Factors

The member meets at least **ONE** of the following risk factors:

1. The individual has a history of inpatient, partial hospitalization, or emergency psychiatric treatment more than once in the members' life; **OR**
2. The member has a history of continuous professional psychiatric supportive care other than hospitalization; **OR**
3. The member has a history of involvement with the criminal justice system; **OR**
4. Services available in the member's community have not been able to meet the member's needs; **OR**
5. The member has a history of unemployment or employment in a sheltered setting or poor work history; **OR**
6. The member has a history of homelessness or is at risk of homelessness if unable to access Habilitation services.

## Section II – Need for Assistance

The member needs assistance demonstrated by meeting at least **TWO** of the following on a continuing or intermittent basis for at least 12 months:

1. The member needs assistance to obtain and/or maintain employment; **OR**
2. The member needs financial assistance to reside independently in the community; **OR**
3. The member needs significant assistance to establish or maintain a personal social support system; **OR**
4. The member needs assistance with at least one activity of daily living (ADL) or instrumental activity of daily living (IADL) to reside independently in the community; **OR**
5. The member needs assistance with management and intervention of maladaptive or anti-social behaviors to ensure the safety of the member and/or others.

"Psychiatric treatment" and "history of psychiatric illness" refer to conditions where diagnosis is typically made and treatment is typically ordered by a psychiatrist, but do not include primary diagnoses of intellectual disability, developmental disability, dementias, or substance induced/use disorder.

## Coding

NA

## Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving and Iowa Medicaid reserves the right to review and update medical policy on an annual or as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards

adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

## References

Iowa Administrative Code 441-78.27(2).

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

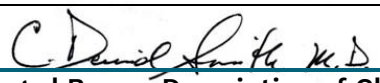
## Criteria Change History

| Change Date | Changed By | Description of Change | Version |
|---|---|---|---|
| **Signature** | | | |

| Change Date | Changed By | Description of Change | Version |
|---|---|---|---|
| 10/17/2025 | CAC | Annual Review. | 9 |
| **Signature** William (Bill) Jagiello, DO | | | |
| **Change Date** | **Changed By** | **Description of Change** | **Version** |
| 10/18/2024 | CAC | Annual review. Updated 2 years to 12 months in Criteria section. Updated Section II – Need for Assistance. | 8 |
| **Signature** William (Bill) Jagiello, DO | | | |
| **Change Date** | **Changed By** | **Description of Change** | **Version** |
| 7/21/2023 | CAC | Annual review. | 7 |
| **Signature** William (Bill) Jagiello, DO | | | |
| **Change Date** | **Changed By** | **Description of Change** | **Version** |
| 7/15/2022 | CAC | Annual review. | 6 |
| **Signature** William (Bill) Jagiello, DO | | | |
| **Change Date** | **Changed By** | **Description of Change** | **Version** |
| 7/16/2021 | CAC | Annual review. Added Compliance section. | 5 |
| **Signature** William (Bill) Jagiello, DO | | | |
| **Change Date** | **Changed By** | **Description of Change** | **Version** |
| 5/27/2020 | BEH Specialist | Added Non-Financial to criteria name. | 4 |
| **Signature** William (Bill) Jagiello, DO | | | |
| **Change Date** | **Changed By** | **Description of Change** | **Version** |

## Criteria Change History

| | | | |
|---|---|---|---|
| 7/21/2017 | CAC | Introductory paragraph removed verbiage “for at least 2 years in order to qualify for Habilitation services”. Section II removed verbiage “for at least 2 years”. This change was incorrect and the deleted text reinserted. | 3 |

**Signature**
C. David Smith, MD 

| Change Date | Changed By | Description of Change | Version |
|---|---|---|---|
| 7/17/2015 | CAC | Added last paragraph in References. | 2 |

**Signature**

| Change Date | Changed By | Description of Change | Version |
|---|---|---|---|
| 7/14/2015 | Medical Director | First paragraph removed reference to admission and subsequent service review. | 1 |

**Signature**

CAC = Medicaid Clinical Advisory Committee