Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Iowa** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Adults with Disabilities Waiver

C. Type of Request: new

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

☒ **New to replace waiver**

Replacing Waiver Number:

IA0213, IA0345, IA0819, IA4111

Base Waiver Number:

Amendment Number (if applicable):

Effective Date: (mm/dd/yy)

Draft ID: **IA.024.00.00**

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

10/01/26

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR § 440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**

☒ **Waiver(s) authorized under section 1915(b) of the Act.**

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

The 1915(b) Iowa High Quality Healthcare Initiative was originally approved with an effective date of April 1, 2016, and was last amended effective February 28, 2024.

Specify the section 1915(b) authorities under which this program operates *(check each that applies):*

☒ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☒ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☒ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under section 1915(i) of the Act.**

☐ **A program authorized under section 1915(j) of the Act.**

☐ **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Iowa HOME Adults with Disabilities (AD) waiver's purpose is to ensure that adults with disabilities across Iowa have access to high-quality behavioral health, disability, and aging services in their communities. A goal of the waiver is to maximize positive outcomes for people who need waiver services, their caregivers, and providers. The Iowa Department of Health & Human Services (HHS) is the single state agency responsible for the oversight of Medicaid.

Applicants may access waiver services by submitting an application to HHS. Iowa HHS' Eligibility Benefit Specialists determine if the member is eligible for Medicaid. Iowa Medicaid's Core Standardized Assessment vendor completes the initial assessment and annual reassessment tools. The Iowa Medicaid's Quality Improvement Organization (QIO) Medical Services Unit contractor determines if the member meets the Level of Care (LOC) criteria initially and annually thereafter.

MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. In the event there is a waiting list for waiver services at the time of application to the waiver, applicants are advised of the waiting list and that they may choose to receive facility-based services. The waitlist includes a prioritization system to ensure that Iowans with the highest need can access services in a timely fashion.

If the applicant is deemed eligible, necessary services are determined through a person-centered planning process with assistance from an interdisciplinary team. After exploring all available resources, including natural and community supports, the member will have the option to choose between various traditional and self-directed services.

The following services are provided under this waiver.

1)Services supporting daily activities and care: Skilled Attendant Care, Attendant Care, Companion, Home Delivered Meals, Home Health Aide, Home Maintenance Support, Respite, Transportation

2)Services helping with health needs: Positive Behavioral Support and Consultation, Family Training, Interim Medical Monitoring and Treatment, Nursing Support, Nutritional Counseling

3)Equipment and modifications: Assistive Devices, Home and Vehicle Modifications, Personal Emergency Response System, Specialized Medical Equipment

4)Day services: Adult Day Care, Prevocational Services, Supported Employment

5)Residential services and support: Assisted living

6)Self-direction supports: Financial Management Services, Independent Support Broker, Individual Goods and Services

7)Other services: Community Transition Services and Peer Mentoring

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who

direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in section 1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization,

psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

HHS seeks continuous and ongoing public input through a variety of modalities, including townhalls, listening sessions, committees, and workgroups. Iowa Medicaid also participates and collaborates with a number of provider and member associations and advocacy groups.

Iowa Medicaid created supplemental public input venues to share updates and solicit input on potential changes to the waiver: (1) formed a steering committee comprised of Medicaid members and Medicaid providers to advise Iowa Medicaid (March 2023-present), (2) surveyed Medicaid members, caregivers, Medicaid providers and case managers on their experiences with community-based services (July 2023), (3) interviewed case managers (July-August, 2023), (4) interviewed individuals on the waiver waitlist (August-September 2023), (5) convened 12 in-person and three virtual public meetings (HOMEtown Conversations October – December 2023), (6) conducted voluntary screenings of individuals on the waiver waitlist (January-June 2024), (7) provided updates and solicited question during Medicaid townhalls with Medicaid members and Medicaid providers (March, May 2024), (8) published on the Iowa Medicaid website and emailed the concept paper that outlined proposed changes, (9) convened three virtual public listening sessions with Medicaid members and Medicaid providers to gather direct feedback on the proposed changes outlined in the concept paper (May 2024), (10) conducted focus groups on additional support needs (May-July 2024); and (11) conducted focus groups on system navigation (July 2024).

The public has the opportunity to comment on Iowa Administrative rules and rule changes through the public comment process, the Legislative Rules Committee, and the HHS Council. Iowa Medicaid also provides notice of applications and amendments by including notice in the Iowa Medicaid e-News emails and on the Iowa Medicaid website.

Iowa Medicaid used the following processes to secure public input into the development of the Adults with Disabilities (AD) Waiver application:

1) Iowa Medicaid Website Posting – Will insert link to public notice from website

2) Iowa Medicaid Public Notice Subscribers - Medicaid members, Medicaid providers, legislators, advocacy organizations and others who wish to remain informed regarding Iowa Medicaid can subscribe to the Iowa Medicaid Public Notice webpage. All subscribers, including those subscribed to Iowa’s HOME contact list, will receive electronic notice whenever an update/public notice is posted. This process includes HCBS waiver applications. The public posting period was the same for this process. The public notice period began on MONTH DATE, 2026 and closed on MONTH DATE, 2026.

[SUMMARIZE PUBLIC COMMENTS]

4) Iowa Tribal Nations Notification - The Tribal Nations were notified of this new waiver via email MONTH DATE, 2026. The comment period remained open through MONTH DATE, 2026.

[SUMMARIZE Tribal COMMENTS]

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Moskowitz

First Name: LeAnn

Title: Program Manager

Agency: Iowa Department of Health and Human Services/Iowa Medicaid

Address: 321 E 12th St.

Address 2:

City: Des Moines, IA

State: **Iowa**

Zip: 50319

Phone: (515) 321-8922 **Ext:** ☐ **TTY**

Fax: (515) 725-1360

E-mail: leann.moskowitz@hhs.iowa.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: McGuire

First Name: Latisha

Title: Federal Compliance Officer

Agency: Iowa Department of Health and Human Services/Iowa Medicaid

Address: 321 E 12th St.

Address 2:

City: Des Moines

State: **Iowa**

Zip:

50319

Phone:

(515) 829-5627 **Ext:** ☐ **TTY**

Fax:

(515) 725-1360

E-mail:

latisha.mcguire@hhs.iowa.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

Grossman

First Name:

Lee

Title:

Medicaid Director

Agency:

Iowa Department of Health and Human Services

Address:

321 E 12th St.

Address 2:

City:

Des Moines

State: **Iowa**

Zip:

50319

Phone:

(515) 380-1785 **Ext:** ☐ **TTY**

Fax:

(515) 725-1360

E-mail:

Lee.Grossman@hhs.iowa.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☒ **Replacing an approved waiver with this waiver.**
- ☒ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☒ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☒ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☒ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Iowa will move from six disability-based waivers to two HOME waivers – the Children and Youth (CY) waiver and the Adult and Disability (AD) waiver. Iowa HHS has conducted extensive engagement across this effort, called Hope and Opportunities in Many Environments (HOME), to provide education on waiver goals and inform person-centered enhancements. Waiver services and coverage policies have been aligned with those previously available to members of Iowa's existing 1915(c) waivers.

Overview of the Children and Youth Waiver and Adult and Disability Waivers
On October 1, 2026, Iowa will begin transitioning from six diagnosis-based 1915(c) waivers into a CY waiver serving members through age twenty and an AD waiver serving those age twenty-one and older. On October 1, 2026, members currently enrolled in the Children's Mental Health (CMH), Health and Disability (HD), Physical Disability (PD), and AIDS/HIV waivers will transition to the CY or AD waivers. Iowa anticipates that members enrolled in the remaining two disability-based waivers, Brain Injury (BI) and Intellectual Disability (ID), will transition at a later date in 2027. The current 1915(c) Elderly waiver will remain unchanged. There is not a planned reduction in the number of current participants because of this waiver restructuring and consolidation. Current waiver members on the CMH, HD, PD, or AIDS/HIV waivers will be deemed eligible for the CY or AD waiver based on their age as of October 1, 2026.

Eligibility
Financial eligibility for the two new waivers is the same as the six diagnosis-based waivers. Clinical eligibility criteria for two new waivers is the same as the six diagnosis-based waivers. To meet the functional eligibility requirements for the AD waiver, members need a level of care provided in a nursing facility (NF), a skilled nursing facility (SNF) or an intermediate care facility for people with intellectual disabilities (ICF/ID). Individuals on the AIDS/HIV waiver meeting the Hospital LOC, will transition to the SNF LOC under this waiver due to the similarities in clinical criteria.

All persons served in one of the six 1915(c) waivers will be eligible for the new CY or AD waivers.

Based on community input and data on service use, Iowa HHS created service packages from which members can access services based on their needs and are not limited based on their specific diagnosis or disability. Iowa HHS developed service packages that retain existing services, add services to meet unmet needs, simplify administration, and eliminate duplication across services available. For services with limits that vary under current waivers, the highest current limit will be carried forth into the two new waivers, ensuring no reduction in service.

Transition Pathways

Members enrolled on a waitlist for an HCBS waiver before October 1, 2026, will move to a waitlist for one of the new waivers, based on their age on October 1, 2026. The waitlist will be based on the application date and those with the highest needs according to the results of the Waiver Priority Needs Assessment (WPNA).

All members enrolled in the CMH, HD, PD, and AIDS/HIV HCBS waivers before October 1, 2026, will transition to either the CY waiver or AD waiver on October 1, 2026 and continue to receive HCBS services as specified in their existing person-centered service plan. Prior to October 1, 2026, members will discuss continuity of care with their case managers and person-centered service plans will be updated for merged or removed services to ensure no gap in service access and no negative impact on the health and welfare of members receiving services. Member's will receive written notification of to the move to the CY or the AD waiver no less than thirty days prior to the change which will include instruction on how to request a State Fair Hearing.

Level-of-care determinations will follow members onto the new waivers. Members will be re-assessed and have their service plan updated in accordance with their annual schedule.

Members pending HCBS waiver enrollment before October 1, 2026, will be transitioned to pending enrollment for their newly applicable HCBS waiver. All children turning 21, and wishing to transition to the AD waiver, in 2026 with a pending waiver slot or on a waiver waiting list will be contacted six months prior to implementation of the new waivers and notified to begin the disability determination process if applicable due to the AD waiver requiring disability for eligibility.

Members newly in need of HCBS services beginning October 1, 2026, will apply for the new waivers, using the Medicaid application. Members who do not have Medicaid will fill out the full Medicaid application. On October 1, 2026, members entering a waitlist for the two new waivers will have the option to be screened to determine their risk of being placed in an institution using WPNA.

Continuity of Care
Members enrolled in the CMH, HD, PD, and AIDS/HIV HCBS waivers before October 1, 2026, will continue to receive HCBS services specified in their existing person-centered service plan, as available, under the two new waivers. From October 2026 to their next person-centered service plan, the CY and AD waivers will have a monthly cap on services by level of care. Participants and case managers will continue to have access to HHS's Waiver of Administrative Rules process to request needed supports and services that exceed the limitations allowed in the waiver.

Case management is not offered on the CY and AD waivers. Members enrolled in managed care will receive case management through their managed care organization. Fee-for-service members will access targeted case management through the state plan.

New services
Iowa HHS has added two new services to both the CY and AD waivers. Community Transition Services pay for important items and one-time services when adults move from a facility to their own home or when youth move to adult services. Peer Mentoring helps members adapt to and stay in their communities with the support, advice, and guidance of someone who has similar experiences. Members enrolled in these waivers will gain access to services that they did not have before, such as Prevocational and Supported Employment. It is the case managers responsibility to monitor the member throughout the transition to identify any unmet needs.

Level of care determination
Starting October 1, 2026, members on the two new waivers will be assessed using a uniform assessment, which is a complete assessment that looks at a person's unique strengths and needs and measures acuity to derive an individualized budget for members.

Individualized budgeting
Individualized budgeting will be used to align member needs with their service spending for the two new waivers. Members will be assigned to a monthly budget category based on their needs and will be able to make informed choices and decisions on what types of services and the amounts used within their monthly budget. A select number of services will be accessed as add-ons that are not subject to members' monthly budget limits.

The individualized budgeting approach is anticipated to launch July 1, 2027. Prior to this launch, beginning October 1, 2026, Iowa HHS will set budget caps based on level of care. This ensures that members can continue their current level of service utilization.

Starting with the second year of a member's transition, individualized budgets will be based on the combination of members' level of care determination and their level of need determined by the uniform assessment.

Provider engagement and qualifications
Iowa HHS is focused on making sure providers are ready to support those they serve by including providers in the development of the redesigned waivers providing access to trainings and resources.

Provider designation process. The State is developing a process to enable providers currentlyenrolled and certified to provide services under one of the current six 1915(c) waivers to becomeauthorizedto provide services under the new waivers for one year after the transition based on their current credentials. Lists of enrolled and certified providers will be provided to managed care organizations to ensure network development and adequacy.

Provider training to support the transition. The State will provide providers and managed care organizations with documentation clarifying training requirements for providers.

Billing during the transition. The State is creating a crosswalk of current 1915(c) billing codes and mapping those to services provided under the CY and AD waivers. Beginning on October 1, 2026, service providers for the CMH, HD, PD, and AIDS/HIV waivers will begin billing using the new billing guidance provided by the state. The past 1915(c) codes will be accepted for at least 6 months after October 1, 2027.

Development of materials, guidance, and infrastructure
The State will issue guidance materials that govern the populations and benefits impacted by this transition and will issue separate guidance targeted for specific audiences. The State will work with providers, MCOs, system navigators, member services call center staff, and other stakeholders to ensure a smooth transition.

Member communications
To ensure impacted members are notified and receive appropriate information relevant to the waiver transition, the State will engage in developing new and updating existing member communication strategy and materials. The member communication materials will use a variety of formats, such as access guides, quick guides, handouts, town halls, trainings, and listening sessions.

Information Technology (IT) Updates
The State will ensure systems for eligibility, enrollment, provider, cost reporting, encounter data, and claims payment support a seamless transition and continuity of care. These efforts are currently underway. The IT updates will support Medicaid managed care enrollment and ensured access to services, as well as provider enrollment and certification. Changes to claims and billing systems will support authorization of fee for service reimbursement, ensure defined allowable scope of benefits, and the ability to monitor expenditures.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Due to the character limitations in the application QP-a2 and SP-c1, and SP-e1 are listed below.

QP-a2: Number and percent of licensed/certified waiver provider re-enrollments verified against the appropriate licensing/certification standards prior to continuing to furnish services.

Numerator: # Number of licensed/certified waiver provider re-enrollments verified against the appropriate licensing/certification standards prior to continuing to furnish services

Denominator: # of licensed/certified waiver provider re-enrollments.

SP-c1: Number and percent of CAHPS respondents who responded “YES” on the CAHPS survey to question 53 “In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?”.

Numerator: Number of CAHPS respondents who responded “YES” on the CAHPS survey to question 53 “In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?”.

Denominator: Total number of CAHPS respondents who were directed to question number 53 due to responding “YES” on the CAHPS survey to question 52 “In the last 3 months, did you ask this {case manager} for help in getting any changes to your services, such as more help from {personal assistance/behavioral health staff and/or homemakers if applicable}, or for help with getting places or finding a job?”.

SP-e1: Number and percent of CAHPS respondents who responded with either “MOST” or "ALL" on the CAHPS survey to question 56 “In the last 3 months, did your service plan include . . . of the things that are important to you”.

Numerator: Number of CAHPS respondents who responded with either “MOST” or "ALL" on the CAHPS survey to question 56 “In the last 3 months, did your service plan include . . . of the things that are important to you”.

Denominator: Total number of CAHPS respondents who responded to the CAHPS survey to question 56 “In the last 3 months, did your service plan include . . . of the things that are important to you”.

Due to character limitations in the application within supported employment service description in appendix C.