STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Employees' Manual
Title 8

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Home- and Community-Based Waivers

Page

Page

Overview

This chapter provides information specific to the Medicaid home- and community-based service (HCBS) waivers, with emphasis on the role of the income maintenance worker.

HCBS waivers provide a variety of services in members' homes that are not available through regular Medicaid. Waiver services are provided only to certain targeted groups for whom a federal waiver has been approved. There are currently seven HCBS waivers, targeting the following groups:

- People who have AIDS or have been infected with HIV (AIDS/HIV)
- People who have a brain injury (BI)
- Children who have a serious mental, behavioral, or emotional disorder (CMH)
- People who are elderly (EW)
- People who are ill or handicapped (HD)
- People who have an intellectual disability (ID)
- People who have a physical disability (PD)

Services are available only to people who meet eligibility criteria, which includes meeting the level of care in a designated medical institution. Eligibility under the waivers is based on the following:

- Income and resource criteria
- Age, disability, or medical need
- Level of institutional care needed
- Need for waiver services
- A determination that the cost of the waiver program does not exceed the established cost limit for the person's level of care

Waiver services are beyond the scope of the Medicaid state plan. Services provided under the waivers are not available to other Medicaid members. Provision of these services must be cost-neutral. The total costs of these services and regular Medicaid cannot exceed the total cost of care and services provided in a medical institution.

General Medicaid eligibility policies in Chapters 8-A through 8-E apply to HCBS applicants and members except where specified in this chapter. For Automated Benefit Calculation system (ABC) data entry instructions, see 14-B(9), *Home- and Community-Based Waiver Case Actions*.

The first section of this chapter covers policies and procedures that are common to all HCBS waivers, such as general application procedures, client participation, reviews, and payment information. The rest of the chapter is divided into sections on the individual HCBS waivers, and the policies and procedures that are unique to each waiver.

HCBS waivers are also discussed in 16-K, *Medicaid Waiver Services*, with an emphasis on the role of case managers. Chapter 16-K provides a detailed description of the enrollment process for each waiver with emphasis on the use of IoWANS.

Legal Basis and History

The legal basis for the Medicaid home and community-based services waivers is found in Section 1915(c) of the Social Security Act. The purpose and intent of a Medicaid HCBS waiver is stated in Section 1902(c) of the Social Security Act. States may request waivers to provide cost-effective home- and community-based services to eligible people so they can avoid or leave institutionalization.

Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981 (OBRA), contains provisions allowing states to request waivers to provide cost-effective home- and community-based services to eligible people so they can avoid or leave residence in a medical institution.

Section 2176 of OBRA amended the Social Security Act to create the HCBS waiver program. The purpose and intent of a Medicaid HCBS waiver is stated in Section 1902(c) of the Social Security Act.

The Omnibus Budget Reconciliation Act of 1987 established that people residing in nursing homes who meet assessment criteria for specialized services to access HCBS waiver programs.

The portions of the Code of Federal Regulations specifically dealing with home- and community-based services are in Title 42, Parts 431.50, 435.3, 435.217, 435.726, 435.735, 440.1, 440.180, 440.250, 441.300 through 441.306, and 441.310. These regulations:

- Specify requirements that the state must meet to be eligible for federal financial participation, and
- Along with the Social Security Act, serve as the basis for state law and administrative rules.

States may seek waivers of the statutory requirements for making the same services available for all Medicaid members on a statewide basis. Waivers are initially approved for a three-year period and after that are renewable every five years.

The Centers for Medicare and Medicaid Services (CMS) allows states to choose to provide waiver services through either a "model" or a "regular" waiver program. A model waiver is limited to 200 members at any one time. Under a regular waiver, participant numbers are established according to a predetermined plan.

The waiver request must be limited to a specified target group, such as the following:

- Aged, disabled, or both
- Intellectually disabled, developmentally disabled, or both
- Mentally ill
- Physically disabled

Members of the target groups must meet the level of care criteria identified in the waiver request.

The total number of people receiving services under any specific Medicaid waiver is limited to the number approved by the secretary of the U.S. Department of Health and Human Services.

To meet the requirement for cost-neutrality, states must demonstrate that the total cost to Medicaid for waiver recipients will not exceed the total cost that Medicaid would incur for these people if they were institutionalized. The financial constraints related to cost neutrality are based on the average cost for the target group, and do not compare costs between HCBS and alternative institutional services on an individual, case-by-case basis.

Legislation authorizing the Iowa Medicaid program is found in Iowa Code Chapter 249A. The portions of the Iowa Administrative Code specifically dealing with Medicaid waiver services are 441 Chapters 24, 77, 78, 79, and 83. The legislative history of Iowa's waivers is as follows:

- 1982 Iowa Acts, Chapter 1260, requested the Department pursue pilot projects to provide HCBS waivers. During 1982, the Department received approval for a Medicaid waiver to fund assessment and case management services through the Iowa Gerontology Model Project in Scott County.
- Health and disability waiver: 1983 Iowa Acts, Chapter 201, requested the Department establish a task force with providers and consumer groups to develop a proposal for a program of home- and community-based services under Medicaid.

  The Department applied for four waivers at the recommendation of the task force. A model waiver for people who are ill or handicapped was the only waiver that was approved. It was effective August 1, 1984, with implementation October 1, 1984, as a model waiver for 50 eligible blind and disabled people. On February 1, 1996, this waiver was converted from a model waiver to a regular waiver. The waiver was renamed as the health and disability waiver effective December 1, 2012.
- Elderly and AIDS/HIV waivers: 1989 Iowa Acts, Chapter 318, directed the Department to seek federal approval of HCBS waivers to provide cost-effective alternative services for elderly people and for people with acquired immunodeficiency syndrome (AIDS). The target population was those who met criteria for placement in a medical institution.

  The model waiver for the elderly was approved for implementation on August 1, 1990, and the AIDS waiver was approved for implementation on February 1, 1991. The model waiver for the elderly was converted to a regular waiver on August 1, 1993.
- Intellectual disability waiver: 1991 Iowa Acts, Chapter 267, Section 130, directed the Department to seek approval of HCBS waivers for people with an intellectual disability.

  The waivers for people with an intellectual disability (ID) and people with an intellectual disability residing in nursing homes (ID/OBRA) were merged and then approved in November 1991 for implementation on March 1, 1992. The waiver was renamed as the intellectual disability waiver effective July 1, 2009.
- Brain injury waiver: 1994 Iowa Acts, Chapter 1160, directed the Department to seek approval of HCBS waivers for people with a brain injury. The waiver for people with a brain injury was approved on May 29, 1996, and implemented on October 1, 1996. Effective July 1, 2014, the age cap of 65 years old was removed.
- Physical disability waiver: 1999 Iowa Acts, Chapter 203, Section 7, directed the Department to seek approval of an HCBS waiver for people with a physical disability. The waiver for people with a physical disability was approved on July 30, 1999, for implementation on August 1, 1999.

- Children's mental health waiver: 2005 Iowa Acts, House File 841, Section 66, directed the Department to seek approval of an HCBS waiver for children with serious emotional disturbance. The waiver for children with serious disturbance was approved on July 1, 2005, for implementation on October 1, 2005.

  NOTE: The children's mental health waiver was originally approved at the federal level as a demonstration waiver under Section 1115a of the Social Security Act, but became a Section 1915(c) waiver effective July 1, 2010. (This is the same authorization as the other six waivers.)

- 2012 Iowa Acts, Senate File 2336 removed the statutory requirements for county governments to pay the nonfederal share of medical assistance costs for services provided under the home- and community-based services intellectual disability waiver or brain injury waiver effective July 1, 2012.

Summary of Waiver Characteristics

Legal reference: 441 IAC 83

The following chart compares the similarities and differences in eligibility factors among the waivers. At the end of this chapter are the specific eligibility requirements for each waiver. Click on the link below under "waiver" to be taken to the specific section.

Waiver	Basic Character	Medicaid Coverage Group	Disability Required?	Level of Care	Other Criteria
AIDS/HIV	Diagnosis of AIDS/HIV	Non-MAGI (including 300% group and MEPD) Children under 21 in the 300% group Medically Needy meets hospital level of care	Yes, for Non-MAGI No, for children under 21 in the 300% group	ICF SNF Hospital	Need services Choose waiver Assigned payment slot
Brain Injury (BI)	Diagnosis of brain injury	Non-MAGI (including 300% group and MEPD) Children under 21 in the 300% group	Yes, for Non-MAGI No, for children under 21 in the 300% group	ICF/ID ICF SNF	At least 1 month of age Need services Choose waiver Assigned payment slot
Children's Mental Health (CMH)	Diagnosis of serious emotional disturbance	Non-MAGI (including 300% group and MEPD) Children under 21 in the 300% group	Yes, for non-MAGI No, for children under 21 in the 300% group	Hospital	Children under age 18 and not in foster care Need services Choose waiver Assigned payment slot
Elderly (EW)	Age 65 or over	Non-MAGI (including 300% group)	No	ICF SNF	Need services Choose waiver Assigned payment slot

Waiver	Basic Character	Medicaid Coverage Group	Disability Required?	Level of Care	Other Criteria
Health and Disability (HD)	Blind or disabled	Non-MAGI (including 300% group and MEPD)	Disabled according to SSI guidelines	ICF SNF ICF/ID	Under age 65 Need services Choose waiver Assigned payment slot
Intellectual Disability (ID)	Diagnosis of intellectual disability	Non-MAGI (including 300% group and MEPD) Children under 21 in the 300% group Foster care	Yes, for non-MAGI No, for children under 21 in the 300% group No, for foster care	ICF/ID	Need services Choose waiver Assigned payment slot
Physical Disability (PD)	Have a physical disability	Non-MAGI (including 300% group and MEPD) Children under 21 in the 300% group	Disabled according to SSI guidelines	ICF SNF	Aged 18 to 64 Ineligible for ID waiver Need services Choose waiver Assigned payment slot

Summary of Waiver Services

The following chart identifies the services available under each HCBS waiver:

Waiver Services	AIDS	BI	CMH	EW	HD	ID	PD
Adult day care	✔	✔		✔	✔	✔	
Assisted living services				✔			
Assistive devices				✔			
Behavioral programming		✔					
Case management		✔		✔			
Chore service				✔			
Consumer choice option	✔	✔		✔	✔	✔	✔
Consumer-directed attendant care	✔	✔		✔	✔	✔	✔
Counseling	✔				✔		
Day habilitation						✔	
Environmental modifications and adaptive devices			✔				
Family and community support services			✔				
Family counseling and training		✔					
Home and vehicle modification		✔		✔	✔	✔	✔
Home-delivered meals	✔			✔	✔		
Home health aide	✔			✔	✔	✔	
Homemaker	✔			✔	✔		
Interim medical monitoring and treatment		✔			✔	✔	

Waiver Services	AIDS	BI	CMH	EW	HD	ID	PD
In-home family therapy			✔				
Mental health outreach				✔			
Nursing	✔			✔	✔	✔	
Nutritional counseling				✔	✔		
Personal emergency response		✔		✔	✔	✔	✔
Prevocational services		✔				✔	
Respite care	✔	✔	✔	✔	✔	✔	
Senior companion				✔			
Specialized medical equipment		✔					✔
Supported community living		✔				✔	
Supported residential-based community living						✔	
Supported employment		✔				✔	
Transportation		✔		✔		✔	✔

Waiver Forms

The following chart lists forms income maintenance workers use in the waiver programs. Directions for completion of these forms are found in 6-Appendix and 16-K-Appendix.

Form	AIDS	BI	CMH	EW	HD	ID	PD
470-5170, *Application for Health Coverage and Help Paying Costs*	✔	✔	✔	✔	✔	✔	✔
470-4833, *Waiver Slot Notice*	✔	✔	✔		✔	✔	✔
470-3924, *Request for IoWANS Changes*	✔	✔	✔	✔	✔	✔	✔

Definitions

Legal reference: 441 IAC 24.1(225C), 83.1(249A), 83.21(249A), 83.41(249A), 83.60(249A), 83.81(249A), 83.101(249A), 83.121(249A)

"Adaptive" means age-appropriate skills related to taking care of one's self and one's ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional activities of daily living, leisure, or work.

"Adult" means a person aged 18 or over.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control, "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of *Morbidity and Mortality Weekly Report*.

"Appropriate" means that the services, supports, or activities provided or undertaken by the organization are relevant to the member's needs, situation, problems, or desires.

"Assessment" means the review of the member's current functioning in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Attorney in fact under a durable power of attorney for health care" means a person that:

- Is designated by a durable power of attorney for health care, pursuant to Iowa Code Chapter 144B, as an agent to make health care decisions on behalf of another person, and
- Has consented to act in that capacity.

"Behavior" means skills related to regulating one's own behavior, including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate socio-sexual behavior.

"Blind person" means a person who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

"Brain injury" means clinically evident damage resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

- Malignant neoplasm of brain, cerebrum
- Malignant neoplasm of brain, frontal lobe
- Malignant neoplasm of brain, temporal lobe
- Malignant neoplasm of brain, parietal lobe
- Malignant neoplasm of brain, occipital lobe
- Malignant neoplasm of brain, ventricles
- Malignant neoplasm of brain, cerebellum
- Malignant neoplasm of brain, brain stem
- Malignant neoplasm of brain, midbrain, peduncle, or medulla oblongata
- Malignant neoplasm of brain, cerebral meninges
- Malignant neoplasm of brain, cranial nerves
- Secondary malignant neoplasm of brain
- Secondary malignant neoplasm of other parts of the nervous system, cerebral meninges
- Benign neoplasm of brain and other parts of the nervous system, brain
- Benign neoplasm of brain and other parts of the nervous system, cranial nerves
- Benign neoplasm of brain and other parts of the nervous system, cerebral meninges
- Encephalitis, myelitis, or encephalomyelitis
- Intracranial or intraspinal abscess
- Anoxic brain damage
- Subarachnoid hemorrhage
- Intracerebral hemorrhage
- Other and unspecified intracranial hemorrhage
- Occlusion and stenosis of precerebral arteries
- Occlusion of cerebral arteries
- Transient cerebral ischemia
- Acute, but ill-defined, cerebrovascular disease

- Other and ill-defined cerebrovascular diseases
- Fracture of vault of skull
- Fracture of base of skull
- Other and unqualified skull fractures
- Multiple fractures involving skull or face with other bones
- Concussion
- Cerebral laceration or contusion
- Cerebral edema
- Cerebral palsy
- Subarachnoid, subdural, or extradural hemorrhage following injury
- Other and unspecified intracranial hemorrhage following injury
- Intracranial injury of other and unspecified nature
- Poisoning by drugs, medicinal or biological substances
- Toxic effects of substances
- Effects of external causes
- Drowning or nonfatal submersion
- Asphyxiation or strangulation
- Child maltreatment syndrome
- Adult maltreatment syndrome
- Status epilepticus

"Case management" means services that assist a member in gaining access to medical, social, and other appropriate services needed for the member to remain in the member's home. Case management is provided at the direction of the member and the interdisciplinary team.

"Child" means a person aged 17 or under.

"Client participation" means the amount of the member's income that the member must contribute to the cost of waiver services, exclusive of medical vendor payments, before Medicaid will participate.

"CMS" means the federal Centers for Medicare and Medicaid Services, which sets federal Medicaid policy and approves waivers to federal Medicaid requirements.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current Supplemental Security Income (SSI) guidelines.

"Department" means the Iowa Department of Human Services.

"Direct service" means consumer services provided face to face.

"**Disabled person"** means a person who is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

NOTE: See 8-C, *Presence of Age, Blindness, or Disability*, for further description of disability and blindness standards.

"Financial participation" means client participation and medical payments from a third party, including veterans' aid and attendance.

"Guardian" means a parent of a minor member or guardian appointed in juvenile or probate court.

"HCBS" means home- and community-based services, which are services intended to enable people to live in their own homes or communities instead of in a medical institution.

"HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

"IME" means the Iowa Medicaid Enterprise.

"IME Medical Services Unit" means the contracted entity in the Iowa Medicaid Enterprise that determines level of care for members initially applying or continuing to receive Medicaid waiver services.

"Intellectual disability" means a diagnosis of intellectual disability that shall be:

- Based on an assessment of the person's intellectual functioning and level of adaptive skills.
- Made by a psychologist or a psychiatrist who is professionally trained to complete the following:
  - Administer the tests required to assess intellectual functioning.
  - Evaluate a person's adaptive skills.
- Made in accordance with the criteria provided in the *Diagnostic and Statistical Manual of Mental Disorders*, Current Edition, published by the American Psychiatric Association.
- Made only when the onset of the person's condition was before the age of 18 years.

"Interdisciplinary team" means a collection of people with varied professional backgrounds who develop one plan of care to meet a member's needs for services.

"Intermediate care facility for persons with an intellectual disability (ICF/ID)" means a medical institution that includes the following:

- Has the primary purpose of the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions, and
- Provides ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or related services to help each resident function at the person's greatest ability in a protected residential setting, and
- Is an approved Medicaid vendor.

"Intermittent supported community living service" means supported community living service provided not more than 52 hours per month.

"IoWANS" means Institutional and Waiver Authorization and Narrative System. This computer program supports the waiver programs by tracking cases and authorizing the IME to make payments to providers.

"Maintenance needs" means costs associated with rent or mortgage, utilities, telephone, food, and household supplies.

"Managed Care Organization (MCO)" means a health plan that coordinates care for a member.

"Medicaid case management" means services established pursuant to Iowa Code Chapter 225C to assist members in gaining access to appropriate living environments, needed medical services, and interrelated social, vocational, and educational services. Case management services have the following responsibilities:

- Linking members to service agencies and support systems responsible for providing the necessary direct service, and
- Coordinating and monitoring those services.

"Medical institution" means an institution that:

- Is organized to provide medical care, including nursing and convalescent care;
- Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;
- Is authorized under state law to provide medical care; and
- Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include:
    - Adequate and continual medical care and supervision by a physician;
    - Registered nurse or licensed practical nurse supervision and services and nurses' aid services sufficient to meet nursing care needs; and
    - A physician's guidance on the professional aspect of operating the institution.

"Mental health professional" means a person who meets all of the following conditions:

- Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing or social work, or is a doctor of medicine or doctor of osteopathic medicine and surgery;
- Holds a current Iowa license when required by the Iowa licensure law; and
- Has at least two years of post-degree experience supervised by a mental health professional in assessing mental health problems, mental illness and needs of people and in providing appropriate mental health services.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps taken to implement a policy.

"Qualified brain injury professional" means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years' experience working with people living with a brain injury:

- A psychologist;
- A psychiatrist;
- A physician;
- A physician assistant;
- A registered nurse;
- A certified teacher;
- A social worker or mental health counselor;
- A physical, occupational, recreational, or speech therapist; or
- A person with a Bachelor of Arts or science degree in psychology, sociology, or public health or rehabilitation services.

"Qualified intellectual disability professional" or **"QIDP"** means a person who has at least one year of experience working directly with people with an intellectual disability or other developmental disabilities and who is one of the following:

- A doctor of medicine or osteopathy.
- A registered nurse.
- A psychologist with a master's degree in psychology from an accredited school.
- A social worker with:
    - A graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body, or
    - A bachelor of social work degree from a college or university accredited or approved by the Council on Social Work Education or a comparable body.
- An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or a comparable body.
- A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or a comparable body.
- A speech-language pathologist or audiologist who:
    - Is eligible for certification of clinical competence in speech-language pathology or audiology by the American Speech-Language Hearing Association or a comparable body, or
    - Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.
- A professional recreation staff member with a bachelor's degree in recreation or in a specialty area such as art, dance, music, or physical education.
- A professional dietitian who is eligible for registration by the American Dietetics Association.
- A human services professional who must have at least a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling or psychology.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder that:

- Is of sufficient duration to meet diagnostic criteria for the disorder specified by the *Diagnostic and Statistical Manual of Mental Disorders*, Current Edition (DSM), published by the American Psychiatric Association; and
- Has resulted in a functional impairment that substantially interferes with or limits a child's role or functioning in family, school, or community activities.

"Serious emotional disturbance" shall not include developmental disorders, substance-related disorders, or conditions or problems classified in DSM as "other conditions that may be a focus of clinical attention," unless they co-occur with another diagnosable serious emotional disturbance.

- The following are developmental disorders as specified in the DSM and are not classified as a serious emotional disorder:
  - Asperger's disorder
  - Autistic disorder
  - Childhood disintegrative disorder
  - Pervasive developmental disorder NOS
  - Rett's disorder
- Substance-related disorders categories include the following as specified in the DSM and are not classified as a serious emotional disorder:
  - Alcohol-related disorders
  - Amphetamine-induced disorders
  - Caffeine-related disorders
  - Cannabis-related disorders
  - Cocaine-related disorders
  - Hallucinogen-related disorders
  - Inhalant-induced disorders
  - Nicotine-related disorders
  - Opioid-related disorders
  - Phencyclidine-related disorders
  - Polysubstance-related disorder
  - Sedative-induced, hynotic-induced, or anxiolytic-induced disorders
  - Other (or unknown) substance-related disorders
- Other conditions that may be a focus of clinical attention are identified in the DSM as having one of following criteria:
  - The problem is the focus of diagnosis or treatment and the person has no mental disorder.
  - The person has a mental disorder but it is unrelated to the problem.
  - The person has a mental disorder that is related to the problem, but the problem is sufficiently severe to warrant independent clinical attention.

"Service plan" means a written member-centered outcome-based plan of services developed using an interdisciplinary process that addresses all relevant services and supports being provided. The service plan can involve more than one agency.

Sufficient details about the written service plan are entered into IoWANS to enable tracking of the case and authorization for IME to make payments. This information in IoWANS is also referenced as a "service plan."

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Substantial gainful activity (SGA)" means productive activities that add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

"Third-party payments" means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency that is liable to pay part or all of the medical costs incurred as a result of injury, disease, or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

Policies Common to All HCBS Waivers

Legal reference: 441 IAC Chapter 83

Each of the HCBS waivers has individual requirements. However, the following processes are common to all programs:

- Enrollment process:
  - Joint administration
  - Use of Institutional and Waiver Authorization and Narrative System
- Application processing:
  - Time limits
  - Choose waiver services
  - Waiver slots
  - Effective date of eligibility
  - Notice of decision completion
- Medicaid eligibility determination:
  - Level of care
  - Income and resources
  - Coverage groups
- Payment for services:
  - Service plan
  - Provider enrollment
  - Third-party payments and client participation
  - Co-payment

- Managing ongoing cases:
  - Monitoring services
  - Temporary absences
  - Redetermination of eligibility
- Adverse actions:
  - Denial of service eligibility
  - Reduction
  - Cancellation (termination)
  - Appeals

Enrollment Process

Legal reference: 441 IAC 83.3(249A), 83.43(249A), 83.62(249A), 83.83(249A), 83.103(249A), 83.123(249A)

The waiver enrollment process involves a sequence of steps needed to be completed before payment for waiver services can be authorized. The Iowa Department of Human Services (DHS) has developed a computer program, named the "Institutional and Waiver Authorization and Narrative System" or "IoWANS," to support the Medicaid waiver and long-term care facility programs. The purpose of IoWANS is to assist workers in these programs in processing and tracking requests. See 14-M for IoWANS user instructions.

Upon approval, participants will use IoWANS to provide the Iowa Medicaid Enterprise with information and authority to make payments to or on behalf of a member. The member is tracked in IoWANS until that member is no longer accessing a waiver program.

A case normally starts with the income maintenance (IM) worker entering information into the Department's Automated Benefit Calculation (ABC) system. The ABC system passes pertinent information about the case to IoWANS. Then IoWANS identifies a key task (called a "milestone") for the IM worker who entered the original data into ABC.

This key task is the first in a series of milestones for actions by case managers, child health specialty clinic workers, and many others.

These milestones form a workflow taking a request for a waiver program to denial or final approval. The normal IoWANS workflow for each waiver can be accessed in IoWANS or in 16-K, *Medicaid Waiver Services*.

A request for waiver program services is processed through an IoWANS workflow that concludes with a milestone for the IM worker to give final approval. When the IM worker gives a positive response to this milestone, the Iowa Medicaid Enterprise (IME) is authorized to make payments to providers. It is important for the IM worker to ensure that all actions, including those outside of IoWANS, are complete and accurate before responding.

The following sections contain more information on:

- Joint administration
- IoWANS roles
- IoWANS milestones
- IoWANS entries
- IoWANS change flows

Joint Administration

Legal reference: 441 IAC 83.2(249A), 83.22(249A), 83.42(249A), 83.61(249A), 83.82(249A), 83.103(249A). 83.123(249A)

The HCBS waiver program requires joint administration between the Department and non-Department agencies. At certain points in the IoWANS process, contact with designated Department and non-Department agencies must be made in order for the IoWANS to proceed.

The income maintenance (IM) worker:

- Determines financial eligibility for Medicaid.
- Approves Medicaid benefits.

The Iowa Medicaid Enterprise (IME):

- Enrolls providers.
- Maintains the application and waiting list for waiver slots.
- Certifies waiver providers.
- Conducts quality assurance reviews required for certification.
- Approves the services ordered in the service plan.

The IME Medical Services Unit is responsible for:

- Determining the member's level of care.
- Assessing service necessity.
- Confirming the diagnosis.

The case manager or integrated health home's responsibilities include:

- Completing appropriate level of care assessment form.
- Assisting, if necessary, with obtaining documentation for the IME Medical Services Unit to complete the level of care assessment.
- Coordinating the development and completion of the member's service plan.
- Locating providers.
- Initiation of waiver services.

Use of Institutional and Waiver Authorization and Narrative System

IoWANS Roles

In IoWANS, specific people will be assigned to the roles, including the following:

- Service worker or case manager (SW/CM)
- Service worker or case manager supervisor (SW/CM Sup)
- Income maintenance worker (IM)
- Iowa Medicaid Enterprise Medical Services Unit (IME)
- Child Health Specialty Clinic staff (CHSC)

Supervisors may assign roles to people they supervise, to other supervisors, and even to themselves. Workers can reassign a role they were given back to their supervisor, but they cannot assign a role to anyone else.

Check your own demographic data when you first appear on a MEMBER STATUS screen. If something needs correction, inform your supervisor.

IoWANS Milestones

IoWANS milestone screens present a question, instruction, or a statement followed by choices for a response on two to five response buttons. See 14-M, *Key Tasks (Milestone) Screens* for illustrations of these screens. See 16-K for the step action chart pertaining to each specific waiver workflow.

All milestones in the process of approving a waiver case must be completed before the IME is authorized to start making payments. Thus, there are no "unimportant" milestones in IoWANS.

When you receive an IoWANS milestone and do not immediately know how to respond, click on the CANCEL button to postpone the needed response. The CANCEL button will close the milestone screen and bring you back to the previous screen. You will be able to access the milestone screen again when you are ready to respond.

NOTE: You do not necessarily need to wait to be notified through IoWANS that another person's task (IoWANS milestone) is completed before starting your work. Do your work as you normally do.

Bear in mind that many things outside IoWANS must happen to support the accomplishment of a milestone (key task). Responding to a milestone, while easy to do on line in IoWANS, may be delayed due to necessary procedures outside of IoWANS.

All users must recognize that often many activities will have to take place outside of IoWANS before a person is ready to respond to a milestone. Remember that while IoWANS tends to speed the process, it does not replace all the work that must still be done.

Some milestones are generated to inform you that some action has taken place. These notification milestones require no action by you other than to acknowledge that you have read the milestone. You should respond to a notification milestone promptly.

If you respond prematurely with insufficient or erroneous information, it may be possible to "undo" the milestone. To see if it is possible, navigate to the STATUS screen for the member by clicking on the STATUS subtab when the member is selected.

If it is possible to undo the milestone, a trashcan icon will display in the last column of the milestone's record. If the undo is not permitted (e.g., if "downstream" milestones have been accomplished), you must contact people who have performed the downstream milestones to arrange for a series of "undo" actions or contact the DHS Service Help Desk for assistance.

IoWANS Entries

Workers make entries into IoWANS, depending on the waiver type. IoWANS entries are "real time," which means changes are visible to all workers once the entry is completed.

Based on information entered into the ABC system, IoWANS may receive an "estimated" level of care. The CLIENT LEVEL OF CARE field may be populated with that estimated level of care. The IME Medical Services Unit can either accept this "initial" level of care or choose something different from the pull-down menu (whichever is correct).

The county of legal settlement may be included in the initial entry of a case in ABC or when a member reapplies after a break in services. After the initial entry, the correct county of legal settlement is maintained in IoWANS. The IM worker should change county of legal settlement in the ABC system to match what is in IoWANS.

IoWANS provides a screen that displays the current and past program request. Use form 470-3924, *Request for IoWANS Changes*, to transmit requests for adding, changing, or terminating program request information in IoWANS when the information can't be submitted directly through IoWANS entries.

IoWANS does not provide the means for changing the demographic information for a member. Enter changes to a member's demographic information in ABC. ABC passes the information to IoWANS. IoWANS will not generate notifications when demographic information changes.

If you believe that a waiver type for a particular member is wrong, it cannot be changed in IoWANS. To change the waiver type on a pending or active case, deny or close the case in ABC and open a new case using the new waiver type.

IoWANS Change Flows

In addition to the normal flows, IoWANS generates a series of milestones known as "change flows" in response to "change" events.

For example, after waiver services are started, a member's health may improve or worsen over time to a point that justifies a new determination of the level of care. In this situation, an IoWANS change flow can be started to accomplish milestone tasks to establish a new level of care and perform associated actions.

IoWANS will start a change flow:

- When an annual Medicaid eligibility review is coming due. The Medicaid eligibility review is tracked outside of IoWANS by the ABC system.
- When IoWANS receives a new client participation amount from ABC that differs from what IoWANS already has. The milestones will differ by waiver type and depending on whether the start date is in the current or a future month, or is in a month before the current month.
- When a case manager clicks on the INIT LOC button found on the PROGRAM REQUESTS screen when a new level of care determination is justified after a waiver case has been approved. This change flow will be to accomplish milestones needed to change the level of care and perform associated actions.
- If IoWANS receives a denial for a case from ABC, the change flow will include canceling all outstanding milestones in the normal flow.
- When IoWANS receives a cancellation from the ABC system due to the death of a member. The milestones will differ depending on whether services had started for that member, and will be different for each specific waiver program.
- If IoWANS receives a denial for a case from the ABC system. The change flow will include canceling all outstanding milestones in the normal flow. With a denial no services will be paid. Therefore, the original workflow does not need to be finished.
- IoWANS starts a notification change flow at 60 days before a health and disability or physical disability waiver member's 65th birthday.
- For children's mental health waiver, the income maintenance worker and the case manager receives an IoWANS milestone 30 days before the child's 18th birthday.

  These notifications are reminders that transition planning must be implemented to ensure that the child has appropriate services when the child turns 18 years of age and the children's mental health waiver services end.

Application Processing

Legal reference: 441 IAC 76 (Rules in Process), 83.3(249A), 83.23(249A), 83.43(249A), 83.62(249A), 83.83(249A), 83.103(249A), 83.123(249A)

Policy: The IM worker determines income and resource eligibility for the waiver programs based on a Medicaid application.

A person who is not currently eligible for Medicaid and chooses to apply for home and community based waiver program services must complete form 470-5170, *Application for Health Coverage and Help Paying Costs*.

A person who is currently Medicaid-eligible is not required to file a new application, unless the person is at the end of a Medically Needy certification period. The date of the waiver request will be one of the following:

- The date that the person or the person's authorized representative signs the section "Verification of HCBS Waiver Consumer Choice," on the designated waiver assessment.

- The date the IM worker receives a signed and dated written statement from the person or the person's authorized representative requesting HCBS.

Procedure: Obtain updated information for current Medicaid members as necessary. Request any additional information needed to determine whether the member meets the eligibility requirements for the waivers.

For persons under age 21 applying for the health and disability waiver notify the Child Health Specialty Clinic. The locations, addresses, and phone numbers of the regional centers are listed on Internet at: https://chsciowa.org/.

Follow the application process as stated in 8-B, *Filing a Medicaid Application*. See 8-B, *Procedures for SSI Applicants or Potential SSI Eligibles* regarding when to make referrals to the Social Security Administration based on the applicant's income and SSI status.

See 8-C, *When the Department Determines Disability*, for an explanation of the disability determination process to be used when the applicant's income is more than SSI standards and the applicant is not receiving social security disability. A disability determination is not required for children under 21 in the 300% group.

The AIDS, brain injury, children's mental health, health and disability, intellectual disability, and physical disability waivers have limits on the number of people who can be served. The state designates the number of people to be served under each waiver. See Waiver Slots.

Applicants may voluntarily withdraw or be determined ineligible at any point during the application process. See Withdrawal of an Application.

Time Limits

Legal reference: 441 IAC 76 (Rules in Process), 83.3(3)"a," 83.23(3)"a," 83.43(3)"a," 83.62(3)"a," 83.83(2)"a," 83.103(2)"a," 83.123(2), 130.2(4)

Policy: Applications for waiver programs must be processed within 45 days unless one or more of the following conditions exist:

- An application has been filed and is pending for federal Supplemental Security Income benefits.
- You have not received information for reasons that are beyond the control of the applicant or the Department.
- The application is pending due to the disability determination process performed through the Department.
- The application is pending because a level of care determination has not been made. (A completed assessment has not been submitted to the IME Medical Services Unit.)

Procedure: When waiting for information to continue processing an application, check the appropriate source weekly. Document the contact in the case record by noting who was contacted, the date of contact, the type of contact, and the results of the contact.

Choose Waiver Services

Legal reference: 441 IAC 83.3(3)"c," 83.23(3)"c," 83.43(3)"c," 83.62(3)"c," 83.83(2)"c," 83.103(2)"d," 83.122(5)

Policy: An applicant must be given the choice between HCBS waiver services and institutional care.

Procedure: Explain to the applicant or the applicant's representative the differences between HCBS waiver and institutional care. The applicant or the applicant's representative can indicate the choice for HCBS waiver by either:

- Marking the waiver box on form 470-5433, *Appendix A Application for Health Coverage,*
- Sending a written request asking for waiver services, or
- Verbally confirming their choice with the IM and IM documents the conservation.

Document the applicant's choice in IoWANS using the "comments" box and also in online narrative.

Waiver Slots

Legal reference: 441 IAC 83.3(2), 83.61(3) and (4), 83.82(4), 83.102(5) and (7), 83.123(1)

Policy: There are limits to the number of members who can receive HCBS. In other words, there are a limited number of HCBS waiver slots. When all waiver slots are assigned, the applicant's name is placed on a waiting list maintained by the Iowa Medicaid Enterprise (IME).

Once a waiver slot is assigned, the slot is available for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program.

If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

Procedure: Request a waiver slot by making ABC entries to initiate an IoWANS workflow. NOTE: If eligibility is dependent upon disability, a disability determination must be done **before** a slot can be assigned.

- For people not currently receiving Medicaid, make the entries by the end of the fifth working day after receipt of a completed application, or within five days after receipt of disability determinations, whichever is later.
- For Medicaid members, make the entries by the end of the fifth working day after receipt of one of the following:
    - A written request for HCBS services signed and dated by the applicant or the applicant's authorized representative, or
    - The appropriate assessment form signed by the member or member's representative indicating the choice of HBCS waiver.

IME will inform you through IoWANS whether a waiver slot is available.

- If a waiver slot is available, continue with the application process.
- If a slot is not available, the applicant is not eligible for a waiver and their name is placed on the waiver waiting list. See Slot Waiting List.

Waiver Slot Reissue and Attrition Guidelines

Waiver slot closure reasons that allow a slot to be immediately reassigned to the next applicant upon notice to the Department (if the waiver has available slots):

- The applicant or member aged out of the waiver for Children's Mental Health (CMH), Physical Disability (PD), and Health and Disability (HD) waivers.
- The applicant or member moved out of state.
- The applicant or member is deceased.

Waiver slot closure reasons that allow a slot to be reassigned to the next applicant after 30 days of closure notice to the IME (if the waiver has available slots):

- The application is withdrawn and notification is made to the DHS Contact Center.
- The applicant or member chose another waiver.
- The applicant or member is in foster care (CMH only).
- The applicant or member is admitted to an Intermediate Care Facility for the Intellectually Disabled (ICF/ID) or Psychiatric Medical Institution for Children (PMIC).

Waiver slot closure reasons that allow a slot to be reassigned to the next applicant after 120 days of closure notice to the IME (if the waiver has available slots):

- The applicant did not respond to the notice from the IM worker (response deadline within 30 days).
- The member or applicant has been admitted to a nursing facility.
- The member or applicant has been denied level of care (LOC).
- The member or applicant has not completed annual Medicaid financial review timely.
- The member or applicant requested waiver to be closed.
- The member or applicant exceeds the allowable financial resources.
- The member or applicant reported other income variables.
- The member or applicant needs cannot be met by the waiver.
- The member did not access one unit of service during the most recent calendar quarter.
- The member or applicant is under juvenile court order.

For members who meet all of the following criteria, the IME will place that member on the waiting list in accordance with the member's original application date for the specific waiver:

- The member had been actively on a waiver but was closed off the waiver, and
- The member requested a slot, and
- The request is received by the IME between days 121-180 after notice of closure.

For members who had been on a waiver but the waiver has been closed for more than 180 days, or applicants who never accessed a waiver, once the waiver slot is closed:

- The member must reapply, and
- The member will have a new application date based upon that date of application.

Slot Waiting List

Policy: If no payment slot is available, the applicant's name is placed on a waiting list maintained by the Iowa Medicaid Enterprise (IME).

Procedure: If a slot is not available, the applicant is not eligible for a waiver. Send a *Notice of Decision* denying services based on the limit and stating that the person's name will be put on a waiting list.

As slots become available, people are selected from the waiting list to keep the number of approved members on the program based on their order on the waiting list.

When a payment slot is assigned to a person who was on a waiting list, use the *Waiver Slot Notice*, form 470-4833, to give written notice to the applicant.

In some cases, an applicant for the Brain Injury Waiver, Children's Mental Health Waiver, Health and Disability Waiver, Intellectual Disability Waiver, and Physical Disability Waiver whose name has been placed on the waiting list may have emergent or urgent need for waiver services. The applicant can complete form 470-5795, *Waiver Priority Need Assessment (WPNA)* and submit it to the Department for consideration of wait list prioritization. If a local office receives this form, forward the form to Iowa Medicaid, Attention: HCBS Wait List, PO Box 36330, Des Moines Iowa 50315 or by email to Waiverslot@dhs.state.ia.us

Service Plans

Legal reference: 441 IAC 83.2(2)"a," 83.7(249A), 83.27(249A), 83.47(249A), 83.67(249A), 83.87(249A), 83.107(249A), 83.127(249A), 130.7(234)

Policy: Each person's need for waiver services shall be assessed and documented in a detailed written format that addresses all plan requirements, and

The service plan is developed by the case manager. Only services included in the approved service plan may be reimbursed.

Effective Date

Legal reference: 441 IAC 83.3(3)"b" and "d," 83.3(4), 83.23(3)"b" and "d," 83.23(4), 83.43(3)"b" and "d," 83.43(4), 83.62(3)"b" and "d," 83.62(4), 83.83(2)"b" and "e," 83.83(3), 83.103(2)"c" and "f," 83.103(3), 83.123(3)

Do not approve a case until the following criteria are met:

- Medicaid eligibility is established.
- Level of care is established.

Waiver eligibility begins on the date when both eligibility requirements have been completed.

The waiver start date can't be before the application date or before the date when level of care was determined.

Waiver services will begin once the case has been approved and a case manager has developed a waiver service plan based on the individual member's needs.

You may establish Medicaid eligibility retroactively for individuals who meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*, but waiver services cannot be paid retroactively.

Retroactive Medicaid Eligibility

Legal reference: 42 CFR 435.914, 435.915(a); 441 IAC 76.13(3)

Medicaid benefits are available for all or any of the three months preceding the month in which the application is filed for an individual who meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions* if:

- The member has paid or unpaid medical bills for covered services that were received during the three-month retroactive period, including a Medicare premium payment; **and**
- The member would have been eligible for a Medicaid coverage group in the month services were received if a Medicaid application had been made.
- Retroactive Medicaid benefits are for regular Medicaid services, such as physician services and drugs. Retroactive Medicaid benefits do not include HCBS waiver services.
- Establish retroactive eligibility in accordance with 8-B, *Determining Eligibility for the Retroactive Period*. Do not apply waiver eligibility criteria for the retroactive period. NOTE: The member does not need to be eligible in the month of application to be eligible in any of the three months before the month of application.

When to Deny an Application

Legal reference: 441 IAC 83.8(1), 83.28(1), 83.48(1), 83.68(1), 83.88(1), 83.108(1), 83.128(1)

Deny an application for HCBS waiver services when you have determined that the applicant is not eligible for waiver services because:

- A slot is not available; or
- Disability, resources, income, level of care, or other Medicaid eligibility factors have not been met.

Deny an application for HCBS waiver services when the case manager notifies you in writing that:

- The applicant is not eligible for the service; or
- The applicant does not need waiver services on at least a quarterly basis; or
- HCBS service needs exceed the total monthly cost allowed or cannot meet the applicant's needs; or
- Needed services are not available or are not received from qualified providers; or
- The service requested is not identified in the applicant's service plan; or
- There is another community resource available to provide the service or similar service free of charge that will meet the applicant's needs; or
- The applicant failed to provide information needed to determine eligibility.

NOTE: An applicant may still be eligible for Medicaid under another coverage group even though the applicant does not qualify for waiver services.

Issue adequate notice when you deny an application. See 8-A, *Notification* for more information about notice requirements. Send a *Notice of Decision* to the applicant.

Grace Period Following the Denial of an Application

Legal reference: 441 IAC 76 (Rules in Process)

Policy: A "grace period" is a specified period of time during which an applicant has the opportunity to "cure" the reason for the denial of an application. The grace period is defined as the 14 calendar days immediately following the date of denial.

"Day one" of the 14-day grace period is the day following the date printed on the notice of decision. If the 14th day falls on a weekend or a state holiday, the 14th day is extended to the next working day for which there is regular mail service.

A previously denied application shall be reconsidered when all information necessary to determine eligibility is provided within 14 calendar days of the date of denial. Any changes reported during the grace period that may affect eligibility must be verified when required by policy and be considered in the eligibility determination.

If the applicant is eligible, the original filing date of the application establishes the effective date of eligibility. Waiver eligibility begins on the date when **all** eligibility requirements have been completed. See Effective Date.

Comment: The grace period does not apply to late payment of premiums or noncooperation. Denial reasons for which a grace period may apply include, but are not limited to, failure to provide information necessary to determine eligibility, denial of level of care, and inability to locate the applicant.

If the application was denied because mail was returned or the Department was otherwise unable to locate the applicant, a new application is not required if the household contacts the Department within the 14 days, provides a current Iowa address, and eligibility can otherwise be established.

Procedure: Based on the case circumstances, take the appropriate action as follows:

- **No information provided:** When no information is provided by the 14th day after the date of denial, no further action is required.
- **Partial information provided:** When some of the information is returned, but there is still information needed to determine eligibility:
  - Attempt to contact the household to let them know what is needed and that if the information is not received so that a decision can be made by the end of the grace period, the household will have to reapply. A written request for the previously requested information is not required.
  - If the information is not provided by the end of the grace period, no further action is necessary.
- **Requested information provided and a change has occurred:** If the original requested information is provided, but the household also reports a change for which verification is necessary:
  - Make every effort to verify the information and inform the applicant that you cannot reconsider the application unless the change is verified by the end of the grace period. If a generic release is on file, use it to obtain the information if possible. A written request for the new information is not required.
  - If the new information is not verified so that an eligibility determination can be made by the end of the 14-day grace period, send a "remain denied" notice. This is because the original reason for denial has been cured, but you cannot process the application due to a change in circumstances that is required to be verified.
  - **Unable to verify change within grace period:** When an additional change is reported and it is unlikely the information can be verified and eligibility established by the end of the 14-day grace period, attempt to notify the applicant that they will need to file a new application.

Comment:

1. Mr. A, a waiver applicant, fails to provide two pieces of information requested by the Department. The IM worker issues a denial notice on April 1, which is dated April 2. Mr. A provides all of the requested information on April 16. There have been no other changes in the household circumstances. The IM worker processes Mr. A's application.
2. Ms. B, a waiver applicant, fails to provide three pieces of information requested by the Department. The IM worker issues a denial notice on May 10, which is dated May 11. Ms. B provides two of the items on May 13. The worker attempts to contact Ms. B about the third item.

   The third item is received on May 25. There have been no other changes in the household circumstances. The IM worker processes the application.
3. Mr. C's application for the elderly waiver is denied on April 20 based on level of care. The IM worker issues a denial notice on April 21, which is dated April 22.

   Mr. C's case manager provides additional information to the IME Medical Services Unit on May 3. IME approves Mr. C's level of care effective May 3. The IM worker reopens Mr. C's application and processes it.

Withdrawal of an Application

When an applicant voluntarily withdraws the application for waiver services during the application process, send a *Notice of Decision* to the applicant. Also notify the following, as applicable:

- The IME Medical Services Unit.
- The case manager.
- The Child Health Specialty Clinics central office (319-356-1035 or toll free at 866-219-9119) for people under age 21 applying for the health and disability waiver.

Medicaid Eligibility Determination

Legal reference: 441 IAC 83.2(249A), 83.21(249A), 83.42(249A), 83.61(249A), 83.82(249A), 83.102(249A), 83.122(249A)

Unless otherwise specified in this chapter, application policies and general eligibility requirements are the same for people applying for HBCS waiver services as for any other applicant. Follow processing procedures described in 8-B, *Application Processing* and eligibility requirements in 8-C, *Nonfinancial Eligibility*, 8-D, *Resources*, 8-E, *Income*, and 8-F, *Coverage Groups*.

In addition to these eligibility requirements, all waiver applicants must meet the institutional level of care requirements specific to that waiver, corresponding to the requirements at 8-I, *Medical Necessity* for applicants in medical institutions.

If the applicant's income is under SSI limits and eligibility is determined under non-MAGI, refer the applicant to the Social Security Administration for application and disability determination, unless the application was previously denied in the past year and circumstances have not changed. See 8-C, *When the Department Follows an SSA Disability Determination*.

Level of care Determination

Legal reference: 441 IAC 83.2(1)"d," 83.22(1)"d," 83.42(1)"b," 83.61(1)"c," 83.82(1)"f," 83.87(3), 83.102(1)"h," 83.122(3)

Policy: Each person applying for waiver services must have a level of care determination done before eligibility can be determined. To be determined eligible for waiver services, the applicant must meet a level of care allowable for the waiver for which the applicant is applying.

Waiver	Level of Care
AIDS/HIV	ICF, SNF, hospital
Brain injury	ICF, SNF, ICF/ID
Children's mental health	Hospital
Elderly	ICF, SNF
Health and disability	ICF, SNF, ICF/ID
Intellectual disability	ICF/ID
Physical disability	ICF, SNF

Procedure: The IME Medical Services Unit certifies if the person meets level of care at time of application. Continued stay reviews are done by IME Medical Services Unit for members who are not with an MCO. For members who are with an MCO, the MCO will complete the continued-stay review.

If a member is denied level of care at the continued stay review, cancel the waiver case for not meeting level of care and send a *Notice of Decision* to the member. The member then has the right to appeal the cancellation.

Income and Resources

Legal reference: 441 IAC 83.2(1)"f," 83.22(1)"c," 83.42(1)"c," 83.61(1)"b," 83.82(1)"b," 83.102(1)"e," 83.122(4)

A waiver member is considered to be an institutionalized person. Treat the member as an institutionalized person for attribution of resources and deeming of income and resources. If a member goes into a medical institution, consider eligibility as if it is a change in facilities, not a change from noninstitutional care to institutional care.

For members eligible under the MEPD coverage group, treat income and resources according to MEPD limits. See 8-F, *Medicaid for Employed People With Disabilities*.

Attribution of Resources

Legal reference: 441 IAC 83.3(5), 83.23(5), 83.43(5), 83.62(5), 83.83(4), 83.103(4)

Policy: When a waiver member is married and has a community spouse, the resource eligibility is determined by the attribution of resources between the spouses.

Procedure: See 8-D, *Attribution of Resources*. Use the first day of the month in which the IME Medical Services Unit determines the waiver member meets level of care as the date to determine the attribution. This date is reported through IoWANS.

Comment: If an attribution was completed for the member in a nursing facility and the member enrolls in waiver, use the previous attribution. Do not complete a new attribution.

Determining Coverage Group

Legal reference: 441 IAC 83.2(1)"a," "b," and "c," 83.22(1)"c," 83.42(1)"c," 83.61(1)"b," 83.82(1)"b," 83.102(1)"e," 83.122(4)

When a person who is not a Medicaid member requests waiver services, establish Medicaid eligibility through a non-MAGI coverage group or through the children under 21 in the 300% group, depending on the waiver type. The non-MAGI coverage group may be a facility coverage group or MEPD. See 8-F, *Coverage Groups*.

For elderly and health and disability waivers, only non-MAGI coverage groups qualify. If the applicant does not qualify under these groups, waiver services cannot be provided. For other waivers, determine eligibility under either the children under 21 in the 300% group or non-MAGI criteria.

For members qualifying in the 300% group, including children under 21 who do not have a disability, services must be expected to last for 30 consecutive days in order to meet the 30 day stay requirement.

Eligibility under most coverage groups includes eligibility for Medicaid HCBS waiver services if the medical necessity requirements are met. Exceptions are as follows:

- The Medically Needy coverage group does not cover nursing facility (NF), skilled nursing facility (SNF), intermediate care facility for persons with an intellectual disability (ICF/ID), psychiatric medical institution for children (PMIC), or waiver services.

  EXCEPTION: If Medically Needy is the only coverage group under which the applicant qualifies, approve waiver services for the AIDS/HIV waiver if the applicant is at hospital level of care. Deny the applicant for all other waivers.

- The qualified Medicare beneficiary (QMB) coverage group provides limited coverage for hospital and skilled nursing care and no coverage for nursing care or ICF/ID care. Only Medicare premiums, coinsurance, and deductibles are covered.

- The qualified disabled and working persons (QDWP) coverage groups provides Medicaid payment only for Medicare Part A premiums.
- The specified low-income Medicare beneficiary (SLMB) and the expanded specified low-income Medicare beneficiary (E-SLMB) coverage groups provide Medicaid payment only for Medicare Part B premiums.

Examine such cases to determine if the members would be eligible for HCBS waiver payment if in another coverage group. Obtain a new application only if a Medically Needy certification is about to end.

For **children** who qualify for facility coverage groups:

- Do not count resources for coverage groups where resources are not considered for children. See 8-D, *Resource Eligibility of Children*.
- Count a parent's income and resources for the first partial month of waiver services. If waiver services begin on a day other than the first day of the month, count the parent's income or resources for that month. See 8-D, *Deeming From a Parent to a Child*, and 8-E, *Deeming From an Ineligible Parent to an Eligible Child*.
- Do not count a parent's income or resources for the first full calendar month of waiver services when waiver is expected to last 30 days. When waiver services begin on the first of the month, do not count the parent's income or resources for that month.

1. Johnny's waiver services are set to begin May 12. Both parents' income is countable to him for May. Johnny is over the income limit for May. Beginning June 1, none of Johnny's parents' income is countable and his income is within the limit. Johnny is eligible for waiver services beginning June 1.
2. Mary's waiver services are scheduled to begin May 1. None of her parents' income is countable to her.

Aid Types

Procedure: The Automated Benefit Calculation (ABC) system uses the aid type for the coverage group in combination with the waiver code to identify the type of waiver case. See 14-B-Appendix, TD01 AID, TD01 MED AID, and TD03 WVR, for instructions.

Treatment of Spouses

For married persons applying for waiver services, treat income and resources separately when one spouse expects to be on the waiver and the other is a community spouse.

The income of the spouse not on the waiver is not considered when determining the waiver spouse's countable income for eligibility, but is considered when determining allowable deductions for client participation.

If the community spouse enters a medical facility, treat the spouses as a married couple living in separate facilities for eligibility. However, a diversion to the community spouse can continue when determining client participation.

When one spouse is currently on the waiver and the other spouse goes onto a waiver, apply the policies in 8-I, *When a Spouse Moves Into the Same Room*. If one spouse has been on the waiver for six months before the other spouse enters the waiver, that spouse can choose to be treated separately.

If eligibility is determined together, add the countable income of both the spouses together and compare the total to two times the 300% limit. Add the countable resources of both spouses and compare the total to the couple resource limit. Each spouse will need their own separate waiver case in the ABC system.

Eligibility for Waiver and MEPD

Policy: Members eligible for MEPD can be eligible for a waiver as long as they also meet the requirements specific to the waiver program they want to access.

Procedure: Members who are eligible for Medicaid only through MEPD but also receive waiver services need two cases opened in the ABC system: one case for the MEPD coverage and one for the waiver.

Open the MEPD case first to allow the information to pass to the MEPD billing system.

Members accessing the waiver through the MEPD program will not have client participation assessed for their waiver case.

Comment: Do not make ABC entries on both cases on the same day.

Eligibility for Waiver and State Supplementary Assistance

Legal reference: 441 IAC 177.4(2)

Policy: A member who is eligible to receive State Supplementary Assistance for in-home health-related care (IHHRC) or residential care facility care (RCF) may also receive waiver services if the following conditions are met:

- The member meets the eligibility requirements of each program.
- Each program provides different services. For example, the elderly waiver provides adult day care and respite and the in-home health-related care program provides the personal care and home maintenance for the same person.

Procedure: Establish two separate cases in ABC: one for waiver eligibility and one for State Supplementary Assistance.

Determine eligibility and client participation according to the rules of each program. There is no client participation in the waiver programs unless the member receives veteran's aid and attendance, long-term care insurance payments, or has a medical assistance income trust.

The in-home health-related care program requires client participation when the member's income is over a specific amount. Apply the aid and attendance and other client participation to either the IHHRC or the waiver first, as the member chooses.

Comment: Do not make ABC entries on both cases on the same day.

Payment for Waiver Services

Legal reference: 441 IAC 75 (Rules in Process), 83.4(2), 83.24(2), 83.44(2), 83.63(2), 83.84(2), 83.104(2)

Policy: Medicaid payment cannot be claimed for waiver services that:

- Are not included in the written service plan; or
- Are furnished **before** the service plan is developed.

If a member's client participation covers all or part of the cost of a service, the provider must collect from the member before billing Medicaid or the MCO.

If a member has Medicare or private insurance that covers all or part of a service, providers of that service must bill Medicare or the insurance company before billing Medicaid or the MCO. If the Medicare or private insurance and client participation do not pay the full amount allowed by Medicaid or the MCO, Medicaid or the MCO will pay the difference.

If the sum of the third-party payment equals or exceeds the estimated cost of waiver services, Medicaid or the MCO will make no payments to waiver service providers but will make payments to other medical vendors, as applicable.

Procedure: Determine the third-party payments and client participation while eligibility is being established. If the member is eligible, the case manager issues a *Notice of Decision* to notify the member and the service provider of the client participation or third-party payments due the provider.

Client Participation

Legal reference: 441 IAC 83.4(249A), 83.24(249A), 83.44(249A), 83.63(249A), 83.84(249A), 83.104(249A)

Policy: Client participation is the amount that a member is required to contribute toward the cost of waiver services. To calculate client participation:

1. Determine only the member's total gross monthly income. See 8-I, *Income Available for Client Participation*.
2. Subtract a maintenance needs allowance of 300% of the current SSI benefit for one person.
3. Add in veteran's aid and attendance and veteran's housebound allowance.

The result is the client participation amount.

Procedure: Make client participation entries on the Automated Benefit Calculation (ABC) system. Notify the case manager of the type and amount of client participation to be paid, if any.

Do not inform the provider or the IME of the client participation. It is a case manager's responsibility to apply the client participation toward a specific service.

Members With a Medical Assistance Income Trust

To calculate client participation for waiver members with a medical assistance income trust, see 8-I, *Members With a Medical Assistance Income Trust*.

Case Maintenance

In general, follow the procedures in 8-G, *Case Maintenance*.

The following chart indicates how IoWANS initiates a milestone for the IME Medical Services Unit to process level of care determinations for various situations. The case manager may request a new assessment when a change in the level of care may be needed.

Situation	Assessment
Initial approval	Yes
Annual level of care review	Yes
Cancellation of waiver services following entry into any medical institution, including a hospital, for less than 30 days	No
Change to different waiver, e.g., moving to elderly waiver at age 65	Yes
Transfer between counties	No
Cancellation	No
Redetermination of waiver eligibility after cancellation following institutionalization for more than 30 days	Yes
Nonroutine changes in level of care (not related to any of the above)	Yes

See the following sections for detailed procedures for the following:

- Members who enter a hospital
- Members who enter a nursing facility or other medical institution
- Reviews
- Members who reach age 65

Member Enters a Hospital

Legal reference: 441 IAC 83.3(4)"d," 83.23(4)"c," 83.43(4)"c," 83.62(4)"d," 83.83(3)"c," 83.103(3)"c," 83.125(2)

When a waiver member's stay in a hospital, is less than 30 days, no system entries are needed. This includes stays in a psychiatric hospital or a psychiatric hospital serving persons under the age of 21.

When a waiver member enters a hospital (for other than respite care funded through a waiver) and stays or is expected to stay more than 30 days:

1. Close the Medicaid waiver case on the ABC system. Use the date of entry into the hospital as the waiver negative date on the ABC TD05 screen. Allow timely notice for Medicaid cancellation.

   Closure of the ABC case triggers an IoWANS change flow that generates milestones to notify the social worker or case manager of the cancellation.

2. Issue a system-generated notice or form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*, canceling the waiver and Medicaid eligibility.

3. Complete a redetermination of eligibility if necessary to keep the member eligible throughout the hospital stay.

4. If the member returns home within 120 days, reopen the waiver case in the ABC system effective on the date that the member returned home and waiver services will begin. ABC entries trigger an IoWANS workflow to restart waiver services.

   NOTE: When a new assessment requested by the case manager results in a change in the level of care determination, follow the procedures under Application Processing and Medicaid Eligibility Determination.

A member who returns home after more than 120 days must reapply for the waiver.

Member Enters a Medical Institution

Legal reference: 441 IAC 83.3(4)"d," 83.23(4)"c," 83.43(4)"c," 83.62(4)"d," 83.83(3)"c," 83.103(3)"c," 83.125(2)"b"

Policy: For this section, "entering a medical institution" includes entering a nursing facility, an intermediate care facility for persons with an intellectual disability, a state mental health institute (for members under age 21 or age 65 or over), or a psychiatric medical institution for children.

Procedure:

1. When a member enters a medical institution other than for respite care funded through a waiver, you can either close the waiver case or transfer the waiver case to a facility medical case.

   - To **close** the waiver case, complete the following process:

     - Make entries to close the waiver case on the ABC system to allow payment to the medical institution. See 14-B(9), *HOME- AND COMMUNITY-BASED WAIVER CASE ACTIONS: Closing Waiver*. Use the date of entry into the medical institution as the waiver negative date. Allow timely notice for the Medicaid cancellation.

       Closure of the waiver case triggers a change flow in the IoWANS system that generates milestones on the waiver program request that notify the case manager of the waiver cancellation.

     - Issue a system-generated notice or form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*, canceling the waiver and Medicaid eligibility.

- Reopen the case with any entries needed to approve medical institution payment. Remove the waiver code from the TD03 screen while medical institution entries are made to ensure that the case is identified as a medical institution case rather than a waiver case.

▪ To **transfer** the waiver case, complete the following process:

- Make entries on the waiver case on the ABC system to transfer the case into a facility medical case. See 14-B(9), *FACILITY CASE ACTIONS: Move: Same Day*. Use the date of entry into the medical institution as the facility positive date.

  Closure of the waiver case triggers a change flow in the IoWANS system that generates milestones on the waiver program request that notify the case manager of the cancellation.

- Issue a system-generated notice or form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistanc*e, approving facility medical assistance.

2. When the member leaves the medical institution and returns home, make any entries needed to close the medical institution payment.
3. If the member returns home within 120 days, make ABC system entries to reopen the waiver effective the date waiver services will be restarted. Entry of the waiver code on the TD03 screen identifies the case as a waiver case rather than a facility case.

   Pending the case before approval is not required. Either pending or approving the waiver will start a new workflow in IoWANS. The IME Medical Services Unit must re-enter the level of care.
4. If the member returns home after more than 120 days, the member must reapply for the waiver.

Reviews

Legal reference: 441 IAC 83.5(249A), 83.25(249A), 83.45(249A), 83.64(249A), 83.85(249A), 83.105(249A), 83.125(249A)

Policy: Eligibility shall be reviewed at least once every 12 months according to the requirements for the member's particular coverage group and waiver. The member shall complete form 470-5482, 470-5482(S), 470-5482(M), or 470-5482(MS), *Medicaid/State Supp Review*, for the annual Medicaid eligibility review.

Procedure: The IM worker evaluates the information on the *Medicaid/State Supp Review* to determine if the member remains eligible for Medicaid under the current coverage group. A redetermination is completed when a change is reported that would result in the member no longer being eligible under the current coverage group.

Respond to IoWANS milestones to record:

- Cancellation of HCBS services,
- A change in level of care, or
- A change in client participation.

Document a change in eligibility in the member's case record and send the appropriate notice of decision to the member.

Members Reaching Age 65

Legal reference: 441 IAC 83.2(1), 83.102(1)"f"

Policy: When health and disability, and physical disability waiver members reach age 65, they are no longer eligible to receive services under those waivers. These members may continue eligibility under the elderly waiver only.

The member may apply for the elderly waiver up to 60 days before the member's 65th birthday by sending a written request to the IM worker.

A new level of care determination is not needed as long as it is current. EXCEPTION: A member at the ICF/ID level of care must qualify under another level of care since there is no ICF/ID level of care under the elderly waiver.

Procedure: For members who are not enrolled with an MCO, IoWANS notifies the case manager when a member is reaching age 65 by issuing a milestone reminder 90 days before the member turns 65.

During this period, the service worker or case manager should contact the member to discuss options for other services to ensure a timely transition and avoid any lapse in services. They should also notify the IM worker if the member wants to continue waiver services through the elderly waiver.

Cancellation

If Medicaid is canceled due to a financial change, entry to a medical institution, or noncompliance by the member, an IoWANS change flow will start. The case manager also needs to cancel the waiver services because of this cancellation.

If the case manager cancels services due to reasons connected with the service plan, the IM worker needs to reexamine eligibility under the current coverage group and complete an automatic redetermination to another Medicaid coverage group as needed.

Issue adequate and timely notice when denying or canceling a case. Complete an automatic redetermination to see if the member is eligible for Medicaid under another coverage group. See 8-G, *Automatic Redetermination*. Also see 8-F, *Continuous Eligibility for Children* to determine when continuous eligibility applies to children leaving a waiver.

When to Cancel

Legal reference: 441 IAC 83.8(2), 83.28(2), 83.48(2), 83.68(3), 83.88(3), 83.108(3), 83.128(2)

Members can be canceled from waiver services for the same reasons that apply to all Medicaid members, such as timely reporting, or failure to cooperate with the Quality Control Unit.

Also cancel waiver services when any of the following occur:

- The member's income or resources exceed the financial guidelines.
- The member refuses to cooperate in establishing level of care, income, or resources.
- The member does not meet level of care criteria.
- The member does not meet other waiver-specified criteria.
- The member is in a hospital or medical institution for at least 30 consecutive days excluding respite care. See Case Maintenance.
- The member, legal guardian, or authorized representative asks for the termination of services.

The case manager may cancel the waiver if:

- Service needs exceed the aggregate monthly costs, service units, or reimbursement maximums.
- Needed services are not available or are not received from qualified providers.
- Another community resource is available to provide the service or a similar service free of charge that will meet the member's needs.
- Minimum service requirements are not met.
- The member no longer needs the service authorized. Waiver eligibility must be canceled if a member is receiving only one waiver service and no longer needs that service.
- The physical or mental condition of the member requires more care than can be provided in the member's own home, as determined by the case manager in consultation with the interdisciplinary team.
- The member's service needs are not met by the services provided.
- The member, legal guardian, or authorized representative requests termination of services.

Reinstatement of a Canceled Case

Legal reference: 441 IAC 7.7(249A), 7.7(6), 76 (Rules in Process)

Policy: Eligibility shall be reinstated without a new application when eligibility can be reestablished:

- Before the effective date of cancellation, or
- After the effective date of cancellation as allowed under Grace Period.

Comment: If you can process the information and make all necessary computer entries before the effective date of cancellation, the case can be reinstated even if the system does not process the information until after the effective date of cancellation.

On April 29, the worker discovers that the member has resources that are over the resource limit. Timely notice must be given (ten days in advance of the effective cancellation date). The worker cannot cancel this case effective May 1. The case remains active for the month of May and is canceled with an effective date of May 31.

If the member verifies that the resources are below the limit before June 1 (the effective date of cancellation) and meets all other eligibility requirements, the waiver case can be reopened without going through the application process.

Procedure: If the waiver case can be reinstated before the effective date of cancellation, no new level of care determination or service plan needs to be completed.
If the waiver case is not reinstated before the effective date of cancellation, treat it as a new application. In either situation, complete all IoWANS milestones on a timely basis.

Issue adequate and (if appropriate) timely notice whenever an attempt at reinstatement is made. See 8-A, *Notification* for notification requirements.

Grace Period

Legal reference: 441 IAC 76 (Rules in Process)

Policy: A "grace period" is a specific period of time during which a member has the opportunity to "cure" the reason for cancellation. The grace period is defined as the 14 calendar days immediately following the effective date of cancellation. If the fourteenth day falls on a weekend or state holiday, the fourteenth day is extended to the next working day for which there is regular mail service.

Eligibility on a canceled case shall be reconsidered when all information necessary to determine eligibility is provided within 14 calendar days of the effective date of cancellation. Any changes reported during the grace period that may affect eligibility must be verified when required by policy and be considered in the eligibility determination.

If the member is eligible, the effective date of assistance shall be the first day of the month following the month of cancellation. See 8-G, *Effect of Nonpayment of Premiums*. See 8-A, *Notification* for notification requirements.

Comment: The grace period does not apply to late payment of premiums or to noncooperation actions.

Cancellation reasons for which a grace period may apply include, but are not limited to, failure to provide information necessary to determine eligibility and inability to find the member.

If the case was closed because mail was returned or the Department was unable to find the member, a new application is not required if the household contacts the Department within the 14 days to provide a current Iowa address and eligibility can otherwise be established.

Procedure: Based on the circumstances of your case, take the appropriate action as follows:

- **No information provided**: When no information is provided by the 14th day after the effective date of cancellation, no further action is required.
- **Partial information provided**: When some of the information is returned, but there is still information needed to determine eligibility:
  - Attempt to contact the household to let the household know what is needed and that if the information is not received by the end of the grace period, the household will have to reapply. Document the contact. A written request for the previously requested information is not required.
  - If the information is not provided by the end of the grace period, no further action is necessary.
- **Requested information provided and a change has occurred**: If the original requested information is provided, but the household also reports a change for which verification is necessary:
  - Make every effort to verify the information and inform the member that you cannot make an eligibility determination unless the change is verified by the end of the grace period. Document the contact. A written request for the new information is not required.
  - If the new information is not verified by the end of the 14-day grace period, send a "Remain Canceled" notice. This is because the original reason for cancellation has been cured, but you cannot determine eligibility due to a change in circumstances that is required to be verified. Document your decision.
  - **Unable to verify change within grace period**: When an additional change is reported and it is unlikely the information can be verified by the end of the 14-day grace period, attempt to notify the member to file a new application. Document the contact.

NOTE: If a generic release is on file, it should be utilized, if possible.

Comment:

1. Mr. M, a Medicaid member, fails to provide three pieces of information requested by the Department. A notice is issued to cancel the case effective May 1 for failure to provide requested information.

   Mr. M provides two of the items on April 17 and the third item on May 5. There have been no other changes in the household circumstances. Medicaid is reinstated for Mr. M effective May 1.

2. Ms. C, a Medicaid member, fails to provide two pieces of information requested by the Department. A notice to cancel the case is issued effective June 1 for failure to provide requested information. Ms. C provides the two items on July 17. Ms. C is not eligible to be reinstated. No additional notice is issued. Ms. C must reapply.

3. On April 1, Ms. G's level of care for the physical disability waiver is reviewed. It is determined that she no longer meets the level of care required. The IM worker receives a milestone indicating level of care is denied, closes the waiver, and issues a *Notice of Decision* dated April 2.

   Ms. G's case manager provides additional information to the IME Medical Services Unit on April 12. IME determines that Ms. G does meet level of care for the PD waiver and approves level of care effective April 12.

   The IM worker reopens the physical disability waiver case on April 14 because additional information was received to approve level of care within the 14-day grace period.

Appeal Rights

Legal reference: 441 IAC 83.9(249A), 83.29(249A), 83.49(249A), 83.69(249A), 83.89(249A), 83.109(249A), 83.129(249A)

Members in the HCBS programs have the same appeal rights as other members. See 1-E, *Appeals and Hearings*, for a description of appeal rights and the appeal process.

Eligibility for the AIDS/HIV HCBS Waiver

Legal reference: 441 IAC Chapter 83, Division III

The AIDS/HIV HCBS waiver pays for services for people with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection who would otherwise require care in a medical institution.

"AIDS" is the medical diagnosis "acquired immunodeficiency syndrome" described in the Center for Disease Control's "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of *Morbidity and Mortality Weekly Report*. *"HIV"* is the medical diagnosis "human immunodeficiency virus infection" based on a positive HIV-related test.

To be eligible for the AIDS/HIV waiver, a person must meet all of the following requirements:

- Be diagnosed by a physician as having AIDS or be infected with HIV. The IME Medical Services Unit is responsible for verifying the applicant's diagnosis.
- Be certified by the IME Medical Services Unit as in need of the level of care that would, but for the HCBS program, otherwise be provided in either a:
  - Nursing facility
  - Skilled nursing facility
  - Hospital
- Be eligible for Medicaid under one of the coverage groups listed below:
  - Non-MAGI
  - Children under 21 in the 300% group
  - Medically Needy if the level of care is hospital
  - 300% group or eligible for SSI but living in a medical institution. See 8-F, *People in a Medical Institution Within the 300% Income Limit*.
- Choose home- and community-based services instead of institutional care.
- Require and use at least one HCBS service quarterly, as determined by the member and the interdisciplinary team.
- Have service needs that can be met within the scope of the waiver and do not exceed the cap established for the HCBS AIDS/HIV program.

Eligibility for the Brain Injury Waiver

Legal reference: 441 IAC, Chapter 83, Division V

The brain injury (BI) waiver pays for services for people with a specific brain injury diagnosis to allow them to live in the community. To be eligible for the brain injury waiver, a person must meet all of the following requirements:

- Have a diagnosis of brain injury as verified by the case manager. See Definitions: Brain Injury, for a list of qualifying diagnosis. The IME Medical Services Unit will verify the brain injury diagnosis.
- Be at least one month of age.
- Be certified by the IME Medical Services Unit as in need of level of care that would, but for the HCBS program, otherwise be provided in either a:
  - Nursing facility
  - Skilled nursing facility
  - Intermediate care facility for persons with an intellectual disability
- Be eligible for Medicaid in one of the following coverage groups:
  - Non-MAGI
  - Children under 21 in the 300% group
  - MEPD
  - The 300% coverage group consistent with a level of care in a medical institution

- Choose home- and community-based services instead of institutional care.
- Require and use at least one HCBS service quarterly, as determined by the case manager, the member, and the interdisciplinary team.
- Have service needs that can be met within the scope of this waiver and that do not exceed the cap established for the HCBS BI program.

Eligibility for the Children's Mental Health Waiver

Legal reference: 441 IAC, Chapter 83, Division VII

The children's mental health (CMH) waiver pays for services for children with a serious mental, behavioral, or emotional disorder. To be eligible for the CMH waiver, the child must meet all of the following requirements:

- Be diagnosed with a serious emotional disturbance. (See Definitions.)
- Be certified by the IME Medical Services Unit as in need of hospital level of care.
- Be eligible for Medicaid in one of the following coverage groups:
  - Non-MAGI
  - Children under 21 in the 300% group
  - MEPD
  - The 300% coverage group consistent with a level of care in a medical institution
- Be under 18 years of age.
- Choose home- and community-based services over institutional care.
- Require and use at least one HCBS service quarterly, as determined by the case manager, the member, and the interdisciplinary team.
- Have service needs that can be met within the scope of this waiver and that do not exceed the cap established for the HCBS CMH program.

Integrated Health Homes

An Integrated Health Home (IHH) is a team of professionals working together to provide whole-person, patient-centered, coordinated care for adults with serious mental illness (SMI) and children with a serious emotional disturbance (SED). This includes those members enrolled in the Habilitation and Children's Mental Health waivers.

Currently, the waiver slot manager will assign the IHH as the CM in IoWANS.

Eligibility for the Elderly Waiver

Legal reference: 441 IAC Chapter 83, Division II

The elderly waiver pays for services to elderly Iowa residents so they can stay in the home instead of entering a nursing facility.

To be eligible for elderly waiver services, a person must meet all of the following requirements:

- Be 65 years of age or older.
- Be certified by the IME Medical Services Unit as in need of a level of care that would, but for the HCBS program, otherwise be provided in either a:
  - Nursing facility
  - Skilled nursing facility
- Be eligible for Medicaid as if the person were in a medical institution. See 8-I, *Medical Institutions*.
- Choose home- and community-based services over institutional care.
- Require and use at least one HCBS service quarterly, as determined by the case manager, the member, and the interdisciplinary team.
- Have service needs that can be met within the scope of this waiver and that do not exceed the cap established for the HBCS elderly waiver program.

Eligibility for the Health and Disability Waiver

Legal reference: 441 IAC Chapter 83, Division I

The health and disability (HD) waiver pays for services for people who are blind or disabled to allow them to live in the community. To be eligible for the health and disability waiver, all of the following requirements must be met:

- Be either blind or disabled, as determined by the receipt of social security disability benefits or through the Department's disability determination process. See 8-C, *Presence of Age, Blindness, or Disability*.

  NOTE: People aged 65 or over are not eligible for the health and disability waiver. The elderly waiver is available statewide.
- Be certified by the IME Medical Services Unit as in need of level of care that would, but for the HBCS program, otherwise be provided in either a:
  - Nursing facility
  - Skilled nursing facility
  - Intermediate care facility for persons with an intellectual disability
- Be eligible for Medicaid in one of the following coverage groups:
  - Non-MAGI
  - MEPD
  - The 300% coverage group consistent with a level of care in a medical institution
- Choose home- and community-based services instead of institutional care.
- Require and use at least one HBCS service quarterly, as determined by the case manager, the member, and the interdisciplinary team.
- Have service needs that can be met within the scope of the waiver and that do not exceed the cap established for the HCBS HD program.

Child Health Specialty Clinics

The Child Health Specialty Clinics (CHSC) is Iowa's statewide program for children and youth with special health care needs. The program's mission is to improve the health status of young people with known or suspected chronic illness or disability from birth to the twenty-first birthday. The program generally does not provide services for acute illness or primary well-child care.

The Department and the CHSC have entered into a written agreement that defines responsibilities of each party in the assessment, planning, and care coordination activities related to non MCO-enrolled applicants and members who are 21 or under. Specialized child health services offered by CHSC include:

- Expert diagnosis and evaluation
- Consultation and training for primary care providers
- Care coordination and related family support services

Clinics and services bring together experts from several agencies and many disciplines, including:

- Audiology
- Cardiology
- Hematology
- Nursing
- Nutrition
- Occupational therapy
- Orthopedics
- Otolaryngology
- Pediatrics
- Physical therapy
- Psychology
- Pulmonology
- Respiratory therapy
- Speech/language
- Other subspecialties

The services of CHSC are made available through 13 regional child health centers and through the CHSC central office, located in Iowa City. The locations, addresses, and phone numbers of the regional centers are listed on Internet at: https://chsciowa.org/.

For questions about these services, you may contact the CHSC central office by phone at 866-219-9119. For questions when enrolling a person age 21 or under in the HD waiver, contact the CHSC central office or a CHSC regional center.

Address correspondence to Health Service Coordinator, Child Health Specialty Clinics at the regional address.

Eligibility for the Intellectual Disability Waiver

Legal reference: 441 IAC Chapter 83, Division IV

The intellectual disability (ID) waiver pays for services to people with a primary diagnosis of an intellectual disability who would otherwise require care in a medical institution. To be eligible for the ID waiver, a person must meet all of the following requirements:

- Have a primary diagnosis of an intellectual disability, as verified by the case manager. The IME Medical Services Unit uses the required assessment tool and support documentation to determine level of care.
- Be certified by the IME Medical Services Unit as in need of the level of care that would, but for the HCBS program, would otherwise be provided in an intermediate care facility for persons with an intellectual disability (ICF/ID).

- Be eligible for Medicaid in one of the following coverage groups:
  - Non-MAGI
  - Children under 21 in the 300% group
  - MEPD
  - The 300% coverage group consistent with a level of care in a medical institution
  - Foster care
- Choose home- and community-based services instead of institutional care.
- Be receiving Medicaid case management services or be identified to receive case management services immediately following waiver enrollment.
- Require and use at least one HCBS service quarterly, as determined by the case manager, the member, and the interdisciplinary team.
- Have service needs that can be met within the scope of the waiver and that do not exceed the cap established by the HCBS ID waiver.

Residential-Based Supported Community Living Waiver Slot

Residential-based supported community living (RBSCL) is a separate service under the ID waiver which requires a specific slot separate from the ID waiver slot. The RBSCL slot does not transfer.

The case manager requests a residential-based support community living slot from the waiver slot manager.

Eligibility for the Physical Disability Waiver

Legal reference: 441 IAC, Chapter 83, Division VI

The physical disability (PD) waiver pays for services for people with a physical disability who would otherwise require care in a medical institution. To be eligible for the PD waiver, a person must meet all of the following requirements:

- Have a physical disability.
- Be blind or disabled as determined by the receipt of Social Security disability benefits or through the Department's disability determination process. See 8-C, *Presence of Age, Blindness, or Disability*.
- Be aged 18 through 64 years.
- Be certified by the IME Medical Services Unit as in need of level of care that would, but for the HCBS program, otherwise be provided in either a:
  - Nursing facility
  - Skilled nursing facility.
- Be eligible for Medicaid in one of the following coverage groups:
  - Non-MAGI
  - Children under 21 in the 300% group
  - MEPD
  - The 300% coverage group consistent with a level of care in a medical institution

- Be ineligible for the HCBS intellectual disability (ID) waiver.
- Choose home- and community-based services instead of institutional care.
- Have service needs that can be met within the scope of the waiver, and with the state supplementary assistance in-home health-related care program, if necessary, and that do not exceed the cap established for the HCBS PD program.
- Have the ability to hire, supervise, and fire the provider as determined by the service worker, and is willing to do so; or have a guardian named by probate court that will take this responsibility on behalf of the member.