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Employees' Manual
Title 16
Chapter K

MEDICAID WAIVER SERVICES

Iowa Department of Human Services

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Overview

This chapter provides information specific to the Medicaid home- and community-based service (HCBS) waivers. Although the chapter covers the roles of all participants in the waiver process, it focuses on the knowledge needed by service workers and case managers to carry out the "service" side of waiver eligibility.

Waiver programs provide services to enable people to live in their own homes or communities instead of in a medical institution. Waiver services are provided only to certain targeted groups for whom a federal waiver has been approved.

Federal waivers are necessary to allow the Department to use federal matching funds to provide services beyond the scope of the Medicaid state plan. Services provided under these waivers are not available to other Medicaid members. The waiver request must show how provision of these services will be cost-neutral as compared to the costs of institutional care.

There are currently seven approved federal waivers, for:

- People who have AIDS or have been infected with HIV
- People who have a brain injury (BI)
- Children with serious emotional disturbance (CMH)
- People who are elderly (EW)
- People with a health and disability (HD)
- People with an intellectual disability (ID)
- People with a physical disability (PD)

Services are available only to people who meet eligibility criteria, which include 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 services to meet the person's needs under the waiver program does not exceed the established cost limit for the person's level of care.

Legal Basis and History

The legal basis for Medicaid home- and community-based services waivers is found in Section 1915(c) of the Social Security Act.

Public Law 97-35, the Omnibus Budget Reconciliation Act (OBRA) of 1981, contained 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 can 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 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 to 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 Center for Medicaid and Medicare Services allows states to choose to provide waiver services through either a “model” or a “regular” waiver program. A model waiver is limited to 200 participants 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:

- Aged, disabled, or both
- Intellectual disability
- Mentally ill
- Physically disabled

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

To meet the requirement for cost-neutrality, states must demonstrate that the total Medicaid cost for waiver participants will not exceed the total cost that Medicaid would incur for those people if they lived in a medical institution. The financial constraints related to cost neutrality are based on the average cost for the target group, and do not compare costs between waiver services and 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 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 member 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.
- Elderly and AIDS/HIV waivers: 1989 Iowa Acts, Chapter 318, directed the Department seek federal approval of HCBS waivers to provide cost-effective alternative services for elderly people and for people with acquired immune deficiency 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 seek approval of HCBS waivers for people with an intellectual disability. Two waiver applications were submitted: one for people with an intellectual disability (ID) and one for people with an intellectual disability residing in nursing homes (ID/OBRA).

  These waivers were merged and then approved in November 1991 for implementation on March 1, 1992. This waiver was renamed the intellectual disability waiver in the waiver renewal effective July 1, 2009.

- Brain injury waiver: 1994 Iowa Acts, Chapter 1160, directed the Department 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.

- Physical disability waiver: 1999 Iowa Acts, Chapter 203, Section 7, directed the Department 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, Chapter 117, section 3, and Chapter 167, Section 13, directed the Department to seek approval of a waiver for children with serious emotional disturbance.

  The children's mental health waiver was federally approved on July 1, 2005, as a demonstration waiver under Section 1115a of the Social Security Act. It was implemented on October 1, 2005. The waiver was approved under Section 1915C of the Social Security Act effective July 1, 2010.

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.

"Area agency on aging" means one of 13 agencies that advocate and provide a focal point for senior services in the 99 Iowa counties.

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

- Is designated pursuant to Iowa Code Chapter 144B as an agent to make health care decisions on behalf 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 the cerebral meninges
- Benign neoplasm of brain and other parts of the nervous system
- Benign neoplasm of brain and the cranial nerves
- Benign neoplasm of brain and the 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 laceration or contusion
- 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

"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.

"Community" means a natural setting where people live, learn, work, and socialize.

"Counseling" means a dynamic process in which the therapist uses professional skills, knowledge, and training to enable individuals using the service to realize and mobilize their strengths and abilities, take charge of their lives, and resolve their issues and problems pursuant to 441 IAC 24.4(14).

"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 member services provided face to face.

"Disabled person" means a person who is unable to engage in any substantial gainful activity due to 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.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

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

"Health" means skills related to the maintenance of one's health, including:

- Eating
- Illness identification, treatment, and prevention
- Basic first aid
- Physical fitness
- Regular physical checkups
- Personal habits

"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, the collective name for the units that administer the Iowa medical assistance programs.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Income maintenance worker" or **"IM worker"** means the Department of Human Services worker who is responsible for determining eligibility for Medicaid and other financial support programs.

"Intellectual disability" means a person with an intellectual disability which is:

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

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

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

- Has the primary purpose of the diagnosis, treatment, or rehabilitation of people with an intellectual disability,
- 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.

"ISIS" means the Individualized Services Information System. This is a computer program that supports the Medicaid facility and HCBS waiver programs by tracking cases and authorizing the Iowa Medicaid Enterprise to make payments to providers.

"Living unit" means a single dwelling unit such as an apartment or house.

"Local office" means the county Department of Human Services office as described in rule 441 IAC 1.4(2).

"Licensed practical nurse (LPN)" means a person licensed to practice nursing in the state of Iowa according to Iowa Code section 152.7.

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

"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:

- Link members to services agencies and support systems responsible for providing the necessary direct service activities, and
- Coordinate and monitor those services.

"Medical assessment" means a visual and physical inspection of the member, noting deviations from the norm, and a statement of the member's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"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.

"Medical intervention" means member care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the member's care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member's plan of care.

"Member" means a person who is eligible for Medicaid under rule 441 IAC 75(234).

"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 and social work; or is a doctor of medicine or of osteopathic medicine and surgery; and
- 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 for those people.

"Natural supports" means services and supports identified as wanted or needed by the member and provided by people not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

"Nursing Facility" means an institution or a distinct part of an institution housing, which is primarily engaged in providing health-related care and services, including, but which is not engaged primarily in providing treatment or care for mental illness or persons with an intellectual disability.

The nursing facility provides continuous nursing care and supervision under the direction of a physician. It is limited to people who have a physical or mental impairment which restricts their ability to perform essential activities of daily living as outlined in criteria and impede their capacity to live independently. Their physical or mental impairment are such that self-execution of the required nursing care is improbable or impossible.

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

"Physical disability" means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities:

- Self-care,
- Receptive and expressive language,
- Learning,
- Mobility,
- Self-direction,
- Capacity for independent living, and
- Economic self-sufficiency.

"Plan of care" means the individualized goal oriented plan of services developed collaboratively with the member and the service provider. The plan of care is reflective of the service plan developed by the service worker or case manager with the member and the interdisciplinary team.

"Policies" means the principles and statements of intent of the organization as defined in 441 IAC 24(225C).

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

"Process" means service or support provided by an agency to a member that will allow the member to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization, or institution.

"Psychiatric Medical Institutions for Children" (PMIC) means a psychiatric medical institution for children that uses a team of professionals to direct an organized program of diagnostic services, psychiatric services, nursing care, and rehabilitative services to meet the needs of residents in accordance with a medical care plan developed for each resident.

"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 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.

"Registered nurse (RN)" means a person licensed to practice nursing in the state of Iowa according to Iowa Code chapter 152.

"Rehabilitation services" means services designed to restore, improve, or maximize the individual's optimal level of functioning, self-care, self-responsibility, independence, and quality of life and to minimize impairments, related to the identified disabilities.

"Related condition" means a severe, chronic disability that meets all the following conditions:

- It is attributable to cerebral palsy or epilepsy; or
- It is attributable to any condition other than mental illness that is found to be closely related to a person with an intellectual disability because the condition:
  - Results in impairment of general intellectual functioning or adaptive behavior similar to that of people with an intellectual disability; and
  - Requires treatment or services similar to those required for people with an intellectual disability;
- It is manifested before a person reaches age 22.
- It is likely to continue indefinitely.
- It results in substantial functional limitations in three or more of the following areas of major life activity:
  - Self-care
  - Understanding and use of language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living

"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*, Fourth Edition (DSM-IV-TR), published by the American Psychiatric Association; and
- Has resulted in a functional impairment that substantially interferes with or limits a consumer'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-IV-TR as "other conditions that may be a focus of clinical attention" (V codes), unless these conditions co-occur with another diagnosable serious emotional disturbance.

"**Service coordination**" means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

"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. It can involve more than one agency.

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

"Skill development" means that the service provided is habilitative and is intended to impart an ability or capacity to the member. Supervision without habilitation is not skill development.

"Skilled nursing facility" means a facility as defined in 42 CFR 483.5.

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

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

"Targeted case management" means services furnished to assist members who are part of a targeted population and who reside in a community setting or are transitioning to a community setting in gaining access to needed:

- Medical,
- Social,
- Educational,
- Housing,
- Transportation,
- Vocational, and
- Other services in order to ensure the health, safety, and welfare of the members.

Case management is provided to a member on a one-to-one basis by one case manager.

"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.

"Usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

Summary of Waiver Services

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

WAIVER SERVICES	AIDS	BI	CMH	EW	HD	ID	PD
Adult day care	✓	✓		✓	✓	✓	
Assistive devices				✓			
Behavioral programming		✓					
Case management		✓		✓			
Chore service				✓			
Consumer-directed attendant care	✓	✓		✓	✓	✓	✓
Counseling	✓				✓		
Day habilitation						✓	
Environmental modifications and adoptive devices			✓				
Family and community support services			✓				
Family counseling and training		✓					
Home and vehicle modification		✓		✓	✓	✓	✓
Home-delivered meals	✓			✓	✓		
Home health aide	✓			✓	✓	✓	
Homemaker	✓			✓	✓		
In-home family therapy			✓				
Interim medical monitoring and treatment		✓			✓	✓	
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 Procedure Codes

Providers must use procedure codes to bill for waiver services. Use the following procedure codes to identify waiver services in the waiver service plan.

Service	AIDS Type B	BI Type F	CMH Type H	Elderly Type C	HD Type A	ID Type D	PD Type P	Modifier
Adult day care (half day)	S5101	S5101		S5101	S5101	S5101		None
Adult day care (full day)	S5102	S5102		S5102	S5102	S5102		None
Adult day care (extended day)	S5105	S5105		S5105	S5105	S5105		None
Adult day care (hourly)	S5100	S5100		S5100	S5100	S5100		None
Assisted living on-call services				T2031				None
Assistive devices				S5199				None
Behavioral programming (health and behavioral intervention)		96152						None
Behavioral programming (mental health plan development)		H0032						None
Behavioral programming (mental health assessment)		H0031						None
Case management (targeted, waiver)		T016	T017	T016		T017		None
CDAC (agency, per hour)	S5125	S5125		S5125	S5125	S5125	S5125	None for unskilled; U3 for skilled
CDAC (agency, per day)	S5125	S5125		S5125	S5125	S5125	S5125	None for unskilled; U3 for skilled
CDAC (individual, per hour)	T1019	T1019		T1019	T1019	T1019	T1019	None for unskilled; U3 for skilled
CDAC (individual, per day)	T1019	T1019		T1019	T1019	T1019	T1019	None for unskilled; U3 for skilled
CDAC (assisted living provider)				S5125				None for unskilled; U3 for skilled

Service	AIDS Type B	BI Type F	CMH Type H	Elderly Type C	HD Type A	ID Type D	PD Type P	Modifier
Chore				S5120				None
Counseling (individual)	H0004				H0004			None
Counseling (group)	96153				96153			None
Day habilitation (per day)						T2020		None
Day habilitation (per hour)						T2021		None
Environmental modifications and adaptive devices (home modifications)				S5165				None
Environmental modifications and adaptive devices (personal care items)				S5199				None
Environmental modifications and adaptive devices (specialized supply)				T2028				None
Family and community support			H2021					None
Family counseling and training		H2021						None
Financial management services	T2025	T2025		T2025	T2025	T2025	T2025	UC required; FMS must not have a modifier
Home-delivered morning meals	S5170			S5170	S5170			UG required
Home-delivered liquid supplemental meal	S5170			S5170	S5170			UG required
Home-delivered noon meals	S5170			S5170	S5170			UG required
Home-delivered evening meals	S5170			S5170	S5170			UG required
Home health aide	T1021			T1021	T1021	S9122		None
Homemaker	S5130			S5130	S5130			None
Home and vehicle modification (home modifications only)		S5165		S5165	S5165	S5165	S5165	None
Home and vehicle modification (vehicle modifications only)		T3029		T3029	T3029	T3029	T3029	None

Service	AIDS Type B	BI Type F	CMH Type H	Elderly Type C	HD Type A	ID Type D	PD Type P	Modifier
IMMT (HH agency home health aide)		T1004				T1004	T1004	None
IMMT (HH agency RN care)		T1002				T1002	T1002	None
IMMT (HH agency LPN care)		T1003				T1003	T1003	None
IMMT (child care center)		T1004				T1004	T1004	Requires use of U3 for SCL and childcare providers
In-home family therapy			H0046					None
Mental health outreach				H0036				None
Nursing (RN)	T1030			T1030	T1030	T1030	S9123	
Nursing (LPN)	T1031			T1031	T1031	T1031	S9124	
Nutritional counseling				97802	97802			None
Nutritional counseling (dietician visit)				97803	97803			None
Personal emergency response (initial fee for install)		S5160		S5160	S5160	S5160	S5160	None
Personal emergency response (monthly)		S5161		S5161	S5161	S5161	S5161	None
Prevocational services (daily)		T2014				T2014		None
Prevocational services (hourly)		T2015				T2015		None
Respite (HH agency, specialized)	S5150	S5150		S5150	S5150	S5150		Specialized requires use of U3; individual must not have a modifier
Respite (HH agency, basic individual)	S5150	S5150		S5150	S5150	S5150		Specialized requires use of U3; individual must not have a modifier
Respite (HH agency, group)	T1005	T1005		T1005	T1005	T1005		None

Service	AIDS Type B	BI Type F	CMH Type H	Elderly Type C	HD Type A	ID Type D	PD Type P	Modifier
Respite (home/non-facility, specialized)	S5150	S5150		S5150	S5150	S5150		Specialized requires use of U3; individual must not have a modifier
Respite (home/non-facility, basic individual)	S5150	S5150		S5150	S5150	S5150		Specialized requires use of U3; individual must not have a modifier
Respite (home/non-facility, group)	T1005	T1005		T1005	T1005	T1005		None
Respite (hospital or NF skilled care)	T1005	T1005		T1005	T1005	T1005		U3 required
Respite (NF)	T1005	T1005		T1005	T1005	T1005		U3 required
Respite (ICF/ID)	T1005	T1005		T1005	T1005	T1005		U3 required
Respite (foster group care)	T1005	T1005		T1005	T1005	T1005		U3 required
Respite (resident camp)	T2036	T2036	T2036	T2036	T2036	T2036		None
Respite (group summer day camp)	T2037	T2037	T2037	T2037	T2037	T2037		None
Respite (group specialized summer day camp)	T2037	T2037	T2037	T2037	T2037	T2037		None
Respite (teen day camp)	T2037	T2037	T2037	T2037	T2037	T2037		None
Respite (weekend on-site camp)	T2036	T2036	T2036	T2036	T2036	T2036		None
Respite (adult day care facility)	T1005	T1005		T1005	T1005	T1005		U3 required
Respite (child care facility)	T1005	T1005		T1005	T1005	T1005		U3 required
Respite (RCF/ID)	T1005	T1005		T1005	T1005	T1005		U3 required
Senior companion				S5135				None
Specialized medical equipment		T2029					T2029	None

Service	AIDS Type B	BI Type F	CMH Type H	Elderly Type C	HD Type A	ID Type D	PD Type P	Modifier
Supported community living (daily)		H2016				H2016		ID waiver requires use of HI; BI waiver must not have a modifier
Supported community living (hourly)		H2015						ID waiver requires use of HI; BI waiver must not have a modifier
Supported community living (residential-based)						H2016		Requires use of U3 for RBSL
Supported employment (job development)		T2018				T2018		UC required (limit to one unit)
Supported employment (employer development)		H2024				H2024		UC required (limit to one unit)
Supported employment (enhanced job search)		H2019				H2019		None
Supported employment (job coaching, hourly)		H2025				H2025		None
Supported employment (enclave, hourly)		H2023				H2023		None
Transportation (regional transit authority)				S0215				None
Transportation (area agency on aging, one way)				T2003				None
Transportation (per mile)			S0215			S0215	S0215	None
Transportation (per trip)							T2003	None
Workman's compensation	T2025	T2025		T2025	T2025	T2025	T2025	UC required, FMS must not have a modifier

Waiver Forms

Implementation of the waiver programs requires close cooperation with all entities involved. These may include DHS income maintenance and service staff, Medicaid targeted case management, the Iowa Department on Aging and the area agencies on aging.

The following service forms are used in the waiver programs. Directions for completion of these forms are found in 16-K-Appendix, 6-Appendix, 17-Appendix, or the waiver provider manual.

Form	AIDS	BI	CMH	EW	HD	ID	PD
470-4694, *Case Management Comprehensive Assessment*		✓	✓	✓		✓	
470-4431, *Consumer Choices Option Individual Budget*	✓	✓		✓	✓	✓	✓
470-5019, *Consumer Choices Option Non-Payroll Reimbursement Request*	✓	✓		✓	✓	✓	✓
470-4429, *Consumer Choices Option Semi-Monthly Time Sheet*	✓	✓		✓	✓	✓	✓
470-4389, *Consumer-Directed Attendant Care (CDAC) Daily Service Record*	✓	✓		✓	✓	✓	✓
470-4430, *Delegation of Budget Authority*	✓	✓		✓	✓		✓
470-4427, *Employment Agreement*	✓	✓		✓	✓	✓	✓
470-3453, *Family Case Plan*		✓	✓	✓	✓	✓	✓
470-4428, *Financial Management Service Agreement*	✓	✓		✓	✓	✓	✓
470-3372, *HCBS Consumer-Directed Attendant Care Agreement*	✓	✓		✓	✓	✓	✓
470-4289, *Home- and Community-Based Services Consumer Choices Option Informed Consent and Risk Agreement*	✓	✓		✓	✓	✓	✓
470-4492, *Independent Support Broker Agreement*	✓	✓		✓	✓	✓	✓
470-0583, *Individual Client Case Plan*	✓	✓		✓	✓	✓	✓
Comm. 271, *Is the Consumer Choices Option Right for You?*	✓	✓		✓	✓	✓	✓

Form	AIDS	BI	CMH	EW	HD	ID	PD
470-4392, *Level of Care Certification for HCBS Waiver Program*	✓			✓	✓		✓
470-3668, *Medicaid County Billing Remittance*		✓				✓	
470-0602, *Notice of Decision: Services*	✓	✓	✓	✓	✓	✓	✓
Supported Employment Readiness Analysis		✓				✓	
470-3923, *Request for Medicaid Services Data Changes and Verifications*	✓	✓	✓	✓	✓	✓	✓
470-5044, *Service Worker Comprehensive Assessment*	✓				✓		✓

Procedures Common to All Waivers

Legal reference: 441 IAC Chapter 83

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

- Use of ISIS, including roles, milestones, entries, and change flows.
- Application processing, including time limits, slot assignment, level of care determination, service plan, effective date, and notice of decision completion.
- Payment for services, including provider enrollment, third-party payments, client participation, and co-payment.
- Managing ongoing cases, including monitoring services, temporary absences, and redetermining eligibility.
- Adverse actions, including denial of service eligibility, reduction, cancellation, and appeals.

Use of ISIS

The Iowa Department of Human Services (DHS) has developed a computer program, named the "Individualized Services Information System" or "ISIS," to support the Medicaid waiver and long-term care facility programs. The purpose of ISIS is to assist workers in these programs in processing and tracking requests. See 14-M for ISIS user instructions.

Upon approval, participants will use ISIS 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 ISIS until that member is no longer accessing a waiver program.

There are certain points in the ISIS process that will require contact with designated DHS central office personnel and other outside entities. These contacts must be made in order for the ISIS process to proceed. These contacts may include the Medicaid arbitrator, HCBS waiver program managers, contacts for HCBS waiver slots and waiting lists, and the Iowa Medicaid Enterprise Medical Services Unit.

Following is the Internet address for the most current listing of these important contacts: http://www.ime.state.ia.us/HCBS/HCBSContacts.html

A case normally starts with a Department 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 ISIS. Then ISIS 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 service workers, case managers, area agency on aging workers, Child Health Specialty Clinic workers, and many others.

These milestones form a workflow taking a request for a facility or waiver program to denial or final approval. The normal ISIS workflow for waivers is fully incorporated into the process descriptions for each waiver that appears later in this manual.

A request for waiver program services is processed through an ISIS workflow that culminates 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 is authorized to make payments to providers. It is important for the IM worker to ensure that all actions, including those outside of ISIS, are complete and accurate before responding.

In addition to the normal flow, ISIS generates series of milestones known as "change flows" in response to "change" events. For example, after a waiver is approved and services have started, a member's health may improve or worsen over time to a point that justifies a new determination of the level of care needed. In this situation, an ISIS change flow can be started to accomplish milestone tasks to establish a new level of care and perform associated actions.

The following sections contain more information on:

- ISIS roles
- ISIS milestones
- ISIS entries
- Events that will start change flows in ISIS

You may use form 470-3923, *Request for Medicaid Services Data Change and Verifications*, to transmit requests for add, change, or terminate Service Plan/Service Spans Request information in ISIS when the information cannot be submitted directly through ISIS entries.

ISIS Roles

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

- Department social work case manager (SW/CM)
- Medicaid or elderly waiver case manager (CM)
- Service worker or case manager supervisor (SW Sup or CM SUP)
- Income maintenance worker (IM)
- Waiver slot manager (SM)
- Iowa Medicaid Enterprise Medical Services Unit (IME)
- Iowa Medicaid Enterprise Medical Services Prior Authorization Reviewer (MS PA Reviewer)
- Facility discharge planner (DP)
- 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.

ISIS Milestones

ISIS milestone screens present a question, an 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.

All milestones in the process of approving a waiver case must be completed before the Iowa Medicaid Enterprise is authorized to start making payments. There are no “unimportant” milestones in ISIS.

When you receive an ISIS milestone and don’t immediately know how to respond, respond by clicking 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 ready to respond.

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

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

All users must recognize that often many activities will have to take place outside of ISIS before a person is ready to respond to a milestone. Remember that while ISIS 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.

You do not necessarily need to wait for ISIS to notify you that another person's task (milestone) is finished before starting your work. Do your work as you normally do.

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.

ISIS Entries

Several workers make entries into ISIS, depending on the waiver type. ISIS 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, ISIS 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 ISIS. The IM worker should change county of legal settlement in the ABC system to match what is in ISIS.

Once the county of legal settlement is established in ISIS, only the county of legal settlement medical arbitrator may change it (with or without information from the county of legal settlement arbitrator). Contact the county of legal settlement arbitrator for any legal settlement changes for members meeting ICF/ID level of care.

ISIS provides a screen that displays the current program request. This screen will eventually show three years of program requests history. Information for programs older than three years will be archived.

You may use form 470-3923, *Request for Medicaid Services Data Change and Verifications*, to transmit requests for adding, changing, or terminating service plan or service spans information in ISIS when the information can't be submitted directly through ISIS entries.

ISIS does not provide the means for changing the demographic information for a member. IM workers enter changes to member demographics information in ABC, and ABC provides the information to ISIS. ISIS will not generate notifications by when demographic information changes.

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

ISIS Change Flows

Normal process flows that take the waiver request to approval are described in the process section for each waiver. In addition to the normal flows, ISIS generates series of milestones known as "change flows" in response to "change" events.

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

ISIS will start a change flow:

- 60 days before the continued stay review date for a waiver case, with milestones to use a new assessment to select (or justify continuing) a level of care.
- 45 days before the service plan review date. The change flow has a milestone to remind the case manager, service worker, area agency on aging worker, or Child Health Specialty Clinic worker (as applicable) of the review.
- A month before a minor receiving ICF/ID level of care changes from a minor to an adult.
- When a change is made to an approved service plan or service with service dates in the current or future months.
- When ISIS receives a new client participation amount from ABC that differs from what ISIS 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, service worker, area agency on aging worker, 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.

- When the Quality Assurance Unit or an HCBS program manager makes a change to a service or enters values in a service plan or service based upon an approved exception to policy. The milestones will differ according to waiver type.
- If ISIS receives a change to county of legal settlement from the ABC system.
- NOTE: Once the county of legal settlement is established in ISIS, it should not be changed in ABC except to make it match what is in ISIS. The change flow will have a milestone prompting the IM worker to investigate whether the county of legal settlement must be changed in ISIS, or the data for county of legal settlement needs to be corrected in ABC.
- If ISIS receives a denial for a case from ABC, the change flow will include canceling all outstanding milestones in the normal flow.
- When ISIS 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 ISIS receives a termination date for a case from the ABC system. The change flow will include canceling all outstanding milestones in the normal flow.

Application Processing

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

The income maintenance (IM) unit, service unit, and, when applicable, Medicaid case managers, area agency on aging workers, Child Health Specialty Clinic workers, and Iowa Medicaid Enterprise reviewers share the responsibility for determining that all waiver eligibility criteria has been met.

The income maintenance unit 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 one of the following forms:

- 470-0462 or 470-0462(S), *Health and Financial Support Application*, when the family is also applying to FIP or Food Assistance, or
- 470-2927 or 470-2927(S), *Health Services Application*, when the application is only for Medicaid.

A person who is currently a Medicaid member 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 Consumer Choice," on the specified waiver assessment.
- The date the income maintenance worker receives a written statement from the person or the person's authorized representative requesting HCBS.

Applicants may voluntarily withdraw or be determined ineligible at any point during the application process. When a person withdraws or is determined ineligible for services, notify:

- The IM worker so that the application process may be stopped.
- The Bureau of Long-Term Care.
- The Child Health Specialty Clinic central office at 319-353-6172 (for people under age 21 applying for the health and disability waiver).

Time Limits

Legal reference: 441 IAC 76.3(249A), 83.3(3)"a," 83.23(3)"a," 83.43(3)"a," 83.62(3)"a," 83.123(3)"a," 130.2(4)

Applications for waiver programs must be processed within 30 days unless one or more of the following conditions exist:

- An application has been filed and is pending for federal Supplemental Security Income benefits.
- The application is pending due to the disability determination process performed through the Department of Human Services.
- 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.)
- The application is pending because the service plan has not been completed.
- The Department has not received information that is beyond the control of the member or the Department of Human Services.

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.

The Department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined ineligible for the program.

Slot Assignment

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

Each of the waivers has an allocated number of "slots" that people can access. The income maintenance worker is responsible for securing the slot under each of the waivers. For procedures, see 8-N, Waiver Slots.

If Medicaid eligibility is dependent upon disability, a disability determination must be done **before** a slot can be assigned. After slot assignment, ISIS refers the applicant for assignment to a service worker or case manager.

When a slot is not available, the applicant is not eligible for the waiver. The IM worker will deny the application and issue a *Notice of Decision* to the applicant as follows:

> "There is a limit on the number of people that can be served. Your name will remain on a waiting list and you will be notified when your turn has come."

The applicant's name will be maintained on the waiting list. As slots become available, applicants are selected from the waiting list to keep the number of approved members on the program, based on their order on the waiting list.

For federal reporting purposes, a waiver slot is assigned for the duration of the waiver statistical year. These waiver years vary for each waiver as follows:

- AIDS/HIV — July through June
- Brain injury — October through September
- Children's mental health — July through June
- Elderly — August through July
- Health and disability — November through October
- Intellectual disability — July through June
- Physical disability — August through July

Therefore, if the waiver applicant reapplies for HCBS at any time during that waiver's statistical year, the person can be reassigned to that slot if otherwise eligible. It is not necessary to apply for a new slot. But if the person reapplies after the end of that waiver's statistical year, use established application procedures to request a waiver slot.

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," 83.107(2), 83.122(3)

As a condition of eligibility for each waiver, the Iowa Medicaid Enterprise (IME) Medical Services Unit must certify that the person meets a level of care covered by that waiver. The level of care determination is based on information submitted to IME on the following forms:

Form	Waiver
470-4392, *Level of Care Certification for HCBS Waiver Program*	AIDS, Elderly, HD, PD
470-4694, *Case Management Comprehensive Assessment*	BI, CMH, Elderly, ID

IME performs a level of care determination at least annually for the ICF/ID, nursing, and skilled nursing levels of care, and every four days for hospital level of care.

An ISIS milestone will indicate nursing, skilled nursing, acute (hospital), or ICF/ID level of care.

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)

As a condition of eligibility, each person's need for waiver services shall be assessed and documented in a plan for service that is completed both:

- In a detailed written format that addresses all plan requirements, and
- As a computer record in ISIS, containing only information needed to track the case and authorize payments by the Iowa Medicaid Enterprise.

Before the initial or annual service plan is completed, an assessment of the consumer's need must be completed using:

- Form 470-4694, *Case Management Comprehensive Assessment*, for the brain injury, children's mental health, elderly, and intellectual disability waivers; or
- Form 470-5044, *Service Worker Comprehensive Assessment*, for the AIDS, health and disability, and physical disability waivers.

The written case plan may be completed on:

- Form 470-0853, *Individual Case Plan*, for adults, or
- Form 470-3453, *Family Case Plan*, for children, or
- A format that complies with the case management requirements of 441 Iowa Administrative Code Chapter 24.

The following federal requirements apply specifically to the paper version of the waiver service plan:

- The service plan must be an individualized plan of care.
- Qualified people must develop the service plan annually, based on a current assessment.
- The service plan must describe:
  - Any medical services
  - All other services including HCBS waiver services
  - Frequency of each services and amount
  - Provider who will furnish each service
  - Beginning and ending dates for each service
- The service plan is subject to the approval of the Iowa Medicaid Enterprise.

A process flow for member enrollment is described in later sections of this manual for each individual waiver. These process flows will indicate when the service plan information must be entered into ISIS.

NOTE: Only services included in the approved service plan (both the written plan and the on-line plan in ISIS) may be reimbursed. The service plan must be approved in ISIS before waiver services are provided.

Waiver services must be provided by providers who are certified or enrolled as HCBS providers, and the provider must be certified or enrolled before service provision. (See Consumer Choices Option Services for exceptions. For applicants interested in accessing this option, offer Comm. 271, *Is the Consumer Choices Option Right for You?*)

In addition to these requirements, each of the waiver programs requires specific service plan information. Refer to the service plan section for each individual waiver for additional requirements.

ISIS Service Plan Entries

Create the ISIS service plan records using the ISIS SERVICE PLAN screen and associated WAIVER SERVICES AGREEMENT WORKSHEET screens.

Claims must match in amounts, service types, and funding streams. Therefore, you must make sure the plan is complete and accurate before responding positively to the ISIS milestone that asks if the plan is complete. (See Waiver Procedure Codes for details.)

A proposed service plan may be entered before level of care is officially established. ISIS checks things like the units and rates for services to see that maximums are not exceeded. These editing features will be useful while building the plan. You may keep changing the plan until it is submitted for approval.

When entering a service for a service plan in ISIS, enter a start and end date for the service (defining what is sometimes called the "service span"). The starting date must be within the current month. Retroactive dates going back further than the current month will require entry by the Unit of Quality Assurance.

ISIS allows you to apply all or a portion of the client participation (the amount the member must pay to providers) to a specific service. See Third-Party Payments and Client Participation for instructions.

When a service plan is submitted for approval by responding to the ISIS milestone that calls for completing the plan, the approval will be for the entire plan. Therefore, it is important that you make certain that the plan is complete and accurate **before** responding to the milestone.

NOTE: ISIS will not allow service workers or case managers to enter an exception to policy into service plans, even when the exceptions are approved. Likewise, the system will not accept exception to policy values in fields on the WORKSHEET screens for entering a service.

To establish exceptions:

- First, enter the plan and services into ISIS with standard values.
- Request an exception to policy using methods outside of ISIS. (See 1-B, EXCEPTIONS TO POLICY.) If there is more than one exception to be requested, submit all exception requests at the same time.
- After the exception to policy has been approved, ask the Quality Assurance Unit or an HCBS program manager to amend the record by entering the approved values.

Once an exception to policy has been entered into a service plan, make any further changes carefully. You may change values for a plan or service, but you must not change services with an exception. Only the Quality Assurance Unit or an HCBS program manager can enter changes into ISIS for services with exceptions.

Effective Date

Legal reference: 441 IAC 83.3(4), 83.23(4), 83.43(4), 83.62(4), 83.83(3), 83.103(3), 83.123(3)

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

- The service plan is approved in ISIS.
- Level of care is established.
- Medicaid eligibility is established.

Waiver eligibility begins on the date when **all three** eligibility requirements have been completed. For people eligible under the 300% coverage group, eligibility shall not begin earlier than the first of the month following the date of application.

The service start date you enter on the service plan in ISIS should match the date the IM worker approves the waiver case in the ABC system. Do not use a date that is before the month that the IM worker determined that Medicaid can start. For example, if the member is over resources for the month of May but will be eligible as of June 1, waiver services can't start any earlier than June 1.

For elderly waiver members, the date services are started can be earlier than the date the case manager service worker actually responds to the milestone task in ISIS to accept the plan. If you don't agree with the service start date, it is your responsibility to negotiate a different date with the case manager before approving the plan. The IM worker should then use the new date on the plan when approving the member in ABC.

No waiver services provided before the approval of eligibility for waiver services can be paid. The IM worker may establish Medicaid eligibility retroactively, but waiver services cannot be paid retroactively. The waiver start date can't be before the application date or before the date level of care was determined.

Notice of Decision Completion

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

Complete a notice of decision once both service and income maintenance financial eligibility determinations for the waiver have been completed. (DHS service workers and case managers use form 470-0602, *Notice of Decision: Services*.) Send the notice to:

- The member or the member's legal representative (or both).
- Providers of the member's services.

Include the following information on the notice of decision:

- Services authorized
- Units of service
- Rates for services
- Providers authorized
- Start and end date for each service authorized
- Information about client participation, if any

"Adequate" notice means a written notice that includes the following:

- A statement of the action being taken.
- The reason for the intended action.
- Manual chapter number and subheading supporting the action.
- An explanation of the right to appeal.
- The circumstances under which assistance is continued when an appeal is filed.

A notice to deny, reduce, or cancel services must be timely, as well as adequate. "Timely" notice means that the notice is mailed at least ten calendar days before the date the action would become effective. The timely notice period begins the day after the notice is mailed.

Payment for Services

Regulations regarding federal financial participation in payment for Medicaid HCBS specify that payment cannot be claimed for waiver services that:

- Are not included in the service plan, as documented in ISIS, or
- Are furnished **before** the development of the service plan.

To be eligible for Medicaid payment, waiver services must be received from providers enrolled in the Medicaid program. Members are responsible for participating in the cost of waiver services to an extent, which is determined by the amount and source of their income. Certain Medicaid services also have copayment requirements.

Provider Enrollment

Legal reference: 441 IAC 79.14(249A)

All providers to be paid through the Iowa Medicaid Enterprise (IME) must enroll as Medicaid waiver providers through the IME before services are begun. The provider shall submit form 470-2917, *Medicaid HCBS Provider Application*, to:

IME Provider Services Unit
P.O. Box 36450
Des Moines, IA 50315

A Medicaid provider handbook that covers provider and member eligibility, waiver service policies, service rate information, and claim submission is available on the Internet either through the IME web site or through the Department's Policy Analysis Web site at:
http://www.dhs.iowa.gov/policyanalysis/PolicyManualPages/MedProvider.htm

The IME Provider Services Unit provides telephone support to answer any billing questions from providers. Call 1-800-338-7909 or 515-256-4609.

Third-Party Payments and Client Participation

Legal reference: 441 IAC 75.2(249A); 75.4(4)"a"; 83.4(249A), 83.24(249A), 83.44(249A), 83.63(249A), 83.84(249A), 83.104(249A), 83.124(249A)

The IM worker enters the source and amount of the client participation or third party liability on the ABC system and the information is passed to ISIS. The service worker or case manager is responsible for applying the client participation amount to a specific service in ISIS.

You can enter no more than the client participation amount as identified on the SERVICE PLAN screen. If the client participation amount from the ABC system is zero, then no entry is required. If the client participation is totally paid toward nonwaiver services, no entry is required.

Generally, indicate the provider of the most costly service as responsible for collecting client participation. If client participation exceeds the cost of that service, divide it among various services. Notify the member and the service provider of any client participation or third party payments by indicating the amount in the fee section on form 470-0602, *Notice of Decision: Services*.

If the sum of the third-party payment and client participation equals or exceeds the established reimbursement amount, Medicaid will make no payments to service providers. The member does retain waiver eligibility.

When including specialized equipment or home and vehicle modification in service plans, the cost can be spread over several months. Example:

> The total cost of a home modification for an HD waiver member at the nursing facility level of care is $4,000. The service worker enters the full amount into ISIS and sends an e-mail to the program manager requesting an override of the service plan in ISIS to allow for the increased amount over the waiver cap.
>
> The worker then tracks a prorated amount of up to $505 on a monthly basis over a period of up to 12 months. At $505 per month, it will take 8 months to encumber the entire cost of the home modification. During this time, the member will have only $399 per month to use on other services and remain below the $904 waiver service cap.

Copayment

Legal reference: 441 IAC 79.1(13)

Medicaid members are required to share in the cost of some optional Medicaid-funded services through copayments. The amount of copayment ranges from $1.00 to $3.00. Copayment is required for services such as prescription medications, medical equipment, and ambulance services. Copayment is not required for waiver services.

Providers of service participating in the Medicaid program may not deny care or services because of the member's inability to pay the copayment. However, this does not change the fact that the member is liable for the charges and does not preclude the provider from attempting to collect copayments.

Payment Under the Consumer Choices Option

Legal reference: 441 IAC 78.34(13), 78.37(16), 78.38(9), 78.41(15), 78.43(15), 78.46(6)

The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member has the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports.

As a condition of participating in the consumer choices option, a member shall sign form 470-4289, *HCBS Consumer Choices Informed Consent and Risk Agreement*, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option. The form identifies the monthly budget amount allowed for the member to buy services and make other purchases related to the member's long-term care needs.

The member must enter into an agreement with the financial management service using form 470-4428, *Financial Management Service Agreement*. (See Financial Management Service for procedures and duties.)

The member must also identify an independent support broker and enter into an agreement with the broker using form 470-4492, *Independent Support Broker Agreement*. (See Independent Support Broker for duties.)

The member may elect to delegate responsibility for developing a budget and directing the services under the consumer choice option. The representative must be at least 18 years old and shall not be a current provider of service to the member.

The member and the representative must sign form 470-4430, *Delegation of Budget Authority*, to designate what responsibilities the representative shall have. The representative shall not be paid for this service.

Individual Budget Amount

Legal reference: 441 IAC 78.34(13)"b," 78.37(16)"b," 78.38(9)"b," 78.41(15)"b," 78.43(15)"b," and 78.46(6)"b"

A monthly individual budget amount shall be established for each member based on the anticipated costs to meet the assessed needs of the member and on the services and supports authorized in the member's service plan.

The following chart lists the services under each waiver that may be accessed through the consumer choices option. (The consumer choices option is not available under the children's mental health waiver.) When approved in a member's service plan, the member may choose to include the cost of these services in an individual budget.

WAIVER SERVICES / WAIVER	AIDS	BI	EW	HD	ID	PD
Assistive devices			✓			
Chore services			✓			
Consumer-directed attendant care (unskilled services only)	✓	✓	✓	✓	✓	✓
Day habilitation					✓	
Home-delivered meals	✓		✓	✓		
Homemaker	✓		✓	✓		
Home and vehicle modification		✓	✓	✓	✓	✓
Prevocational		✓			✓	
Respite (basic individual)	✓	✓	✓	✓	✓	
Specialized medical equipment		✓				✓
Supported community living		✓			✓	
Supported employment		✓			✓	
Senior companion			✓			
Transportation		✓	✓		✓	✓

To determine the amount of funds to allocate for most services, the Department determines an average unit cost for the service based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment. This unit cost is multiplied by the number of units of service the member needs, as listed in the service plan.

Anticipated costs for assistive devices, home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost calculation. The anticipated costs shall not include the costs of the financial management services or the independent support broker.

NOTE: Before becoming part of the individual budget, all assistive devices, home and vehicle modification and specialized medical equipment, supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker.

In aggregate, cost of individual budget services must not exceed the current costs of waiver program services.

In order to maintain cost neutrality, the Department also applies a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

The Department computes a utilization adjustment factor for the following services:

- Chore services
- Consumer-directed attendant care
- Day habilitation
- Home-delivered meals
- Homemaker
- Prevocational services
- Supported community living
- Supported employment other than services to obtain a job
- Senior companion
- Transportation

The utilization factor is calculated by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data.

The utilization adjustment factor shall be no lower than 60 percent. The Department analyzes and adjusts the utilization adjustment factor at least annually in order to maintain cost neutrality.

The total adjusted cost of the services required for the member becomes the individual budget amount. The member shall be informed of the amount. The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

Costs for assistive devices, home and vehicle modification and specialized medical equipment, supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment.

Development of the Individual Budget

Legal reference: 441 IAC 78.34(13)“e” & “h,” 78.37(16)“e” & “h,” 78.38(9)“e” & “h,” 78.41(15)“e” & “h,” 78.43(15)“e” & “h,” 78.46(6)“e” & “h”

The independent support broker shall assist the member in developing and implementing the member’s individual budget. The individual budget shall include:

- The costs of the financial management service.
- The costs of the independent support broker.
- The costs of any services and supports chosen by the member. (See Consumer Choices Option Services for descriptions of allowable and nonallowable services in the individual budget.)
- The amount allocated for any approved home or vehicle modification.

  NOTE: Before going into the individual budget, all home and vehicle modifications shall be identified in the member’s service plan and be approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

- Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined under Consumer Choices Option Services. See Savings Plan for requirements.

The member and the independent support broker may reallocate funds among services included in the budget except as noted above.

Before initiating services, the member or personal representative and the member's independent support broker shall complete form 470-4431, *Consumer Choices Option Individual Budget.* This form:

- Identifies the specific needs of the member.
- Identifies the employees working with the member, including the independent support broker and the representative, if applicable, and an emergency backup plan for services.
- Specifies the activities, employee rate per hour, number of hours provided, taxes, and monthly cost for services.
- Lists individual-directed goods and services by description, cost per item or service, frequency, and monthly costs.

Employer Authority

Legal reference: 441 IAC 78.34(13)"g," "i" & "j"; 78.37(16)"g," "i" & "j"; 78.38(9)"g," "i" & "j"; 78.41(15)"g," "i" & "j"; 78.43(15)"g," "i" & "j"; 78.46(6)"g," "i" & "j"

Under the consumer choices option, the member has authority over the individual budget authorized by the Department to perform the following tasks:

- Contract with entities to provide services and supports.
- Determine the amount to be paid for services. NOTE: Reimbursement rates for the independent support broker are subject to a cap of $14.77 per hour. Reimbursement of the financial management service is made at a fixed rate.
- Schedule the provision of services.
- Authorize payment for waiver goods and services identified in the individual budget.

The member shall have the authority to be the common-law employer of employees providing services and support. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- Recruit employees.
- Select employees from a worker registry.
- Verify employee qualifications.
- Specify additional employee qualifications.
- Determine employee duties.
- Determine employee wages and benefits.
- Schedule employees.
- Train and supervise employees.

Any person employed by the member to provide services under the consumer choices option shall negotiate form 470-4427, *Employment Agreement*, with the member that outlines the employee's and the member's responsibilities.

Before initiation of the service, the member and the employee must enter into form 470-4428, *Financial Management Service Agreement*, with the designated financial institution.

The Department releases funds in the individual budget to the financial management service. The service provider shall submit invoices and timecards to the financial management service within 30 days from the date when the service was provided using:

- Form 470-4429, *Consumer Choices Option Semi-Monthly Time Sheet*, or
- Form 470-5019, *Consumer Choices Option Non-Payroll Reimbursement Request*.

The financial management service shall process and pay invoices for approved goods and services included in the individual budget. See Financial Management Service for more information.

Savings Plan

Legal reference: 441 IAC 78.34(13)"f," 78.37(16)"f," 78.38(9)"f," 78.41(15)"f," 78.43(15)"f," and 78.46(6)"f"

A member savings plan must be in writing and be approved by the Department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

The savings plan shall identify:

- The specific goods, services, supports or supplies to be purchased through the savings plan.
- The amount of the individual budget allocated each month to the savings plan.
- The amount of the individual budget allocated each month to meet the member's identified service needs.
- How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

Except for funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received.

- Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.
- The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month.

Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies.

The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

- Be used to meet a member's identified need,
- Be medically necessary, and
- Be approved by the member's case manager or service worker.

See Excluded Services for a list of items and services that cannot be purchased with funds from the individual budget.

All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

Managing Ongoing Cases

The service worker or Medicaid case manager is responsible for the following:

- Monitoring service utilization.
- Making a face-to-face visit to the member at least annually.
- Completing service eligibility and level of care reviews at least annually (or more often if there is a significant change in the member's situation, condition or level of care).
- Participating in the development and approval of the service plan (both on paper and in ISIS) in coordination with the interdisciplinary team.

This chart summarizes the forms used to process waiver services for the actions listed below. Please see specific manual sections for routing instructions.

Situation	Assessment	Service Plan	Notice of Decision
Initial approval	✓	✓	✓
Annual level of care review	✓	Only when level of care changes	Only when level of care changes
Change in provider		✓	✓
Change in provider rates		✓	Only if service amount is decreased due to a rate increase
Change in service start date		✓	✓
Change in service units		✓	Only for a decrease in units
Change to different waiver	✓	✓	✓
Facility stay for more than 30 days	✓	✓	✓
Failure to meet level of care			✓
Failure to use minimum service	✓	✓	✓
Waiver termination			✓

Monitoring Services

Monitor service provision by reviewing the "claims" report in ISIS under "My Reports." Verify that:

- The member used a waiver service at least once a calendar quarter.
- The services were provided in accordance with the service plan on ISIS.

Check the number of units and rates billed by the provider with the amount authorized on the member's service plan on ISIS.

If the services billed are **less than** authorized in the service plan on ISIS:

1. Verify that the member is receiving the level of service needed.

2. Review previous claims report to determine if the member is consistently receiving fewer services than the service plan states. If so, adjust the service plan accordingly.

3. Copy the "claims" report and keep in the member file. This information will assist with service plan development.

If services billed **exceed** those authorized in the service plan on ISIS:

1. Contact the provider via letter or telephone to determine why the service billed is more than the service plan authorization. (If making the contact by telephone, document your call.)

2. Request the provider to adjust the initial claim through the IME claims adjustment process.

If the provider **agrees** to adjust the claim, check the applicable box on the *Client Services Report* with supporting documentation of the provider contact and response. Check for the adjustment on the next *Client Service Report*. If the adjustment doesn't occur within the following three months, contact the provider.

If the provider **refuses** to adjust the claim:

- For an adult on the ID waiver, communicate your findings by submitting the claims report along with documentation of provider contact and responses to the HCBS ID program manager.
- For all other cases, explain in writing that the services billed are greater than authorized in the service plan. Add documentation stating the situation and your correspondence with the provider. Sign and date the report. Send information to the appropriate HCBS program manager in the Bureau of Long-Term Care.

Temporary Absence in a Hospital

Legal reference: 441 IAC 83.23(4)"g," 83.34(4)"d," 83.43(4)"c," 83.62(4)"d," 83.83(3)"c," 83.103(3)"c," 83.125(2)"b"

When a member's hospital stay is **less** than 30 days, no entries are needed. When a 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. Contact the IM worker to close the waiver case on the ABC system. The effective date of cancellation and the end date for waiver is the date of entry to the hospital. Timely notice is necessary for Medicaid cancellation. Send a *Notice of Decision*.

2. Closure of the case on the ABC system triggers a change flow in the ISIS system, generating milestones that notify the social worker or case manager of the cancellation.

3. The IM worker completes a redetermination to the appropriate Medicaid coverage group.

   - If it is not known when the member will return home, eligibility is redetermined under another Medicaid coverage.
   - If the member already returned home before the effective date of cancellation and waiver services will be restarted by the time of the ABC entries, the waiver case should be re-opened.

4. If the member returns home **within** 30 days **or** after 30 days but **before** the effective date of cancellation on the *Notice of Decision*, contact the IM worker.

   - If waiver services **will** be provided:
     - The IM worker makes entries in the ABC system to open the waiver effective on the date that the member returned home and waiver services will begin. The waiver code will identify the case as a waiver case rather than a facility case.
     - ABC entries to pend or approve the waiver will start a new workflow in ISIS to approve resumption of waiver services. The case can be pended before approval, but pending is not required if the case manager can give a start date.

- When waiver services will be provided, make entries to open the waiver effective the date waiver services will be restarted.
- The IME Medical Services Unit will need to re-enter the level of care.
- The case manager or service worker will need to build a service plan.

♦ If waiver services will **not** be provided, the IM worker will complete a redetermination for other coverage groups.

5. If the member returns home **after** more than 30 days or after the effective date of cancellation, a new application process must be initiated.

Temporary Absence in a Nursing Facility or Institution

Legal reference: 441 IAC 83.23(4)"c," 83.34(4)"d," 83.43(4)"c," 83.62(4)"d," 83.83(3)"c," 83.103"c," 83.125(2)"b"

For this section, ICF/ID, MHI, psychiatric hospital, out-of-state nursing facilities (NF or SNF), and PMIC are included as "institutions."

When a member enters a nursing facility or institution for a reason other than to use respite care funded through a waiver, complete the following process:

1. Contact the IM worker to report that the member entered a facility.

♦ The IM worker must:

- Close the waiver case on the ABC system to allow facility payment.
- Cancel the waiver effective on the day of entry to the facility.
- Allow timely notice for the Medicaid cancellation.
- Send a *Notice of Decision*.

♦ Closure of the case on the ABC system triggers a change flow in the ISIS system that includes a generation of milestones that notify you of the cancellation.

♦ The IM worker makes any entries needed to approve facility payment.

2. If the member returns home **within** 30 days or after 30 days but **before** the effective date of cancellation on the *Notice of Decision*, contact the IM worker.

3. If the member returns home **after** more than 30 days or **after** the effective date of cancellation, a new application process must be initiated.

Redetermining Eligibility

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)

A member's waiver eligibility shall be redetermined:

- At least every 12 months.
- When there is a change in the member's situation or condition that affects eligibility.

A redetermination shall include:

- Reviewing and updating the service plan.
- Redetermining level of care.
- Redetermining Medicaid eligibility.

Review the member's situation to ensure that the services in the plan continue to be necessary to meet the member's needs.

- For the AIDS, BI, HD, ID, and PD waivers, develop a current service plan (both written and in ISIS) in coordination with the interdisciplinary team.
- For the elderly waiver, participate in the development and approval of the service plan (both written and in ISIS) with the interdisciplinary team.

The Iowa Medicaid Enterprise (IME) Medical Services Unit is responsible for making a level of care determination for each waiver member at least every 12 months (or when there is a change in the member's circumstances).

The IME Medical Services Unit will send a copy of the specified waiver assessment to the income maintenance worker, service worker, Medicaid case manager, or QIDP who initially submitted the form to IME. This level of care determination is subject to appeal procedures.

The IM worker is responsible for:

- Completing a redetermination of the member's Medicaid financial eligibility.
- Redetermining continuing eligibility factors when a change in circumstances occurs.

Members Reaching Age 65

Legal reference: 441 IAC 83.2(1), 83.82(1)"c," 83.102(1)"f"

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

ISIS notifies the service worker or case manager of this need by issuing:

- A milestone six months before the member turns age 65 which states, "This consumer will turn age 65 in 6 months, which at that time will make them ineligible for this waiver. Begin process of transferring them to another waiver."
- Another reminder 90 days before the member turns 65 with the same language.

When you receive this milestone, take the following steps to make a timely transition and avoid any lapse in services:

- Contact the member to discuss options for other services.
- Notify the income maintenance worker if the member wants to continue waiver services through the elderly waiver.

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 income maintenance worker.

The income maintenance worker would then pend the case in ISIS.

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 another level of care since there is no ICF/ID level of care under the elderly waiver.

Most level-of-care reviews are completed annually. However, a specific level of care may only be granted based on the member's current condition. If the level of care will expire within the next month, a new level of care must be completed.

1. Mr. S is transferring from the health and disability waiver to the elderly waiver on June 1. His last level of care determination was made on January 1. That level of care is valid only until July 1 due to a surgery that placed Mr. S at a skilled level of care.

   Mr. S is required to have a new level of care determination by July 1, so he must have a new determination made before he can transfer to the elderly waiver.

2. Ms. D is transferring from the brain injury waiver to the elderly waiver on March 1, 2011. Her last level of care determination was completed on June 1, 2010. She does not need to have a new level of care determined to transfer to the elderly waiver. However, her level of care will need to be reviewed by June 1, 2011.

Adverse Actions

Legal reference: 441 IAC 7.7(1), 83.8(249A), 83.28(249A), 83.48(249A), 83.68(249), 83.88(249A), 83.108(249A), 83.128(249A), and 130.5(234); 42 CFR 431.200

The following sections address conditions for:

- Denial of waiver services due to service eligibility factors
- Reduction of waiver services
- Cancellation of waiver services
- Appeals of any of these actions

Denial of Service Eligibility Factors

Legal reference: 441 IAC 83.3(2)"b"(4), 83.8(1), 83.28(1), 83.48(1), 83.61(4)"b"(2), 83.68(1), 83.82(4)"b"(2), 83.88(1), 83.102(5)"b"(2), 83.108(1), 83.128(1)

When denying an application due to service eligibility factors, immediately notify the IM worker in writing when you determine that one or more of the following exist:

- The applicant fails to provide information to the service worker or Medicaid case manager that is needed to determine eligibility.
- The applicant does not need waiver services on a regular basis (at least quarterly).
- The applicant's waiver service needs exceed the total monthly allowed or the need cannot be met by the waiver services provided.
- Needed services are not available or are not received from qualified providers.
- There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the person's needs.
- The applicant is not eligible for the service.
- The service is not identified in the applicant's approved service plan, as documented in ISIS.

Complete form 470-0602, *Notice of Decision: Services*, and send it to the applicant, the applicant's legal representative, or both, with a copy to the IM worker. The IM worker uses this information to deny the waiver application.

See Notice of Decision Completion for instructions on timely and adequate notice. See specific waiver sections for further denial instructions.

Reduction of Service

Legal reference: 441 IAC 83.8(3), 83.28(3), 83.48(3), 83.68(2), 83.88(2), 83.108(2), 83.128(3), and 130.5(3)"a" and "b"

Reduce a particular service, in consultation with the interdisciplinary team, when one of the following conditions occurs:

- The member no longer needs services at the currently authorized amount.
- Another community resource is available to provide the same or similar service to the member at no financial cost to the member that will meet the person's needs.

If a member is receiving multiple waiver services, waiver eligibility is not affected by the reduction of one service.

Complete form 470-0602, *Notice of Decision: Services*, and send a copy to:

- The member and the member's legal representative (if applicable).
- The member's service providers.

See Notice of Decision Completion for instructions on timely and adequate notice. See specific waiver sections for further reduction instructions.

Cancellation of Waiver

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

Waiver services may be canceled when one or more of the following applies:

- The member does not meet level of care criteria.
- The member does not meet other waiver-specified criteria.
- The member has not completed or provided required documents.
- The member is in a medical institution for more than 30 consecutive days (excluding respite care funded through the waiver).
- The member or the member's legal guardian or authorized representative requests the termination of services.

- After repeated assessment, it is evident that the member is unable to achieve or maintain the goals set forth in the service plan (HD, AIDS, or elderly only).
- The member's service needs exceed the aggregate monthly costs, service units, or reimbursement maximums.
- Needed services are not available or are not received from qualified providers.
- 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.
- Another community resource is available to provide the service or a similar service that will meet the member's needs to the member free of charge.
- The member's service needs are not met by the services provided.
- 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 service worker or case manager in consultation with the interdisciplinary team.
- The service requested is not identified in the member's approved service plan, as documented in ISIS.
- The member receives services from other Medicaid waiver programs.

Complete form 470-0602, *Notice of Decision: Services*, and send it to the member or the member's legal representative, with a copy to the IM worker. The IM worker uses this information to cancel the waiver eligibility.

See Notice of Decision Completion for instructions on timely and adequate notice. See specific waiver sections for further cancellation instructions.

Appeals

Legal reference: 441 IAC 7.8(17A), 83.9(249A), 83.29(249A), 83.49(249A), 83.69(249A), 83.89(249A), 83.109(249A), and 83.129(249A)

When a member or the member's authorized representative expresses dissatisfaction in writing with any decision, action, or failure to act with reference to the case, determine from the nature of the complaint whether the person wishes to appeal and receive an appeal hearing before an administrative law judge.

The member may appeal to the Department of Human Services:

- A denial, reduction, or cancellation of a waiver service.
- A denial of an application or cancellation of the subsidy payment.

Assist the member with filing an appeal if requested. See 1-E, Filing an Appeal, for the procedure to file an appeal with the Department. See also 1-E, Submitting Information and Continuation of Assistance Pending Final Appeal Decision, for your responsibilities when an appeal is filed.

AIDS/HIV Waiver

Legal reference: 441 IAC 77.34(249A), 78.38(249A), 79.1(2), 79.1(15), Chapter 83 Division III

The Medicaid home- and community-based services (HCBS) acquired immunodeficiency syndrome and human immunodeficiency virus (AIDS/HIV) waiver provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost-effective.

The Department of Human Services works jointly with the Department of Public Health on behalf of people in Iowa diagnosed as having AIDS or HIV to improve coordination between Medicaid and Title II of the Ryan White CARE Act. People working on behalf of the Ryan White CARE Act may assist a member in applying for and obtaining HCBS AIDS/HIV waiver services.

AIDS/HIV waiver services are available to both children and adults. A designated number of members (payment slots) can be served under the HCBS AIDS/HIV program.

The services that are considered necessary and appropriate for the member must be determined through an interdisciplinary team. The team will include the applicant, the applicant's parent or guardian, a DHS service worker, and service providers. The team may also include a representative from the AIDS Coalition of HIV Consortia, an AIDS case manager, and other people the applicant chooses.

Members may be eligible for assistance through the rent subsidy program in addition to services available through the AIDS/HIV waiver. Members interested in applying for rent subsidy should contact the following address:

Iowa Finance Authority
HCBS Rent Subsidy Program
2015 Grand Ave.
Des Moines, IA 50312

The following sections explain:

- Waiver eligibility criteria
- The member enrollment process
- The services available under the waiver

AIDS/HIV Waiver Eligibility Criteria

Legal reference: 441 IAC 83.42(249A), 83.43(4)

To be eligible for AIDS/HIV waiver services, an applicant must:

- Be diagnosed by a physician as having AIDS or HIV infection.
- Be determined by the Iowa Medicaid Enterprise (IME) Medical Services Unit to need nursing facility or hospital level of care.
- Be eligible for Medicaid:
  - Under an SSI-related or FMAP-related coverage group,
  - As medically needy at the hospital level of care,
  - Under special income level (300 percent group), or
  - Through application of the institutional deeming rules.

The IME Medical Services Unit is responsible for contacting the physician to establish the diagnosis. A determination of disability is not required.

Waiver applicants may be Medicaid members before requesting waiver services or may be determined to be Medicaid-eligible through the waiver application. Medicaid eligibility may be available through the waiver program even if the applicant has previously been determined to be ineligible for Medicaid.

Conditions of AIDS/HIV Eligibility

Legal reference: 441 IAC 83.42(249A)

The applicant must choose home- and community-based services as an alternative to institutional services.

As a precondition of eligibility for the AIDS/HIV waiver, applicants shall access all other services for which they are eligible and which are appropriate to meet their needs. Following is the hierarchy for accessing services:

- Through private insurance
- Through Medicaid, including EPSDT (Care for Kids)
- Through the AIDS/HIV waiver
- Through State Supplementary Assistance in-home health-related care. (NOTE: This relationship is discussed further under consumer-directed attendant care. See Relationship to Other Services.)

In order to receive AIDS/HIV waiver services, an approved AIDS/HIV waiver service provider must be available to provide those services.

The member must need and use one of the available AIDS/HIV waiver services during each quarter of the calendar year.

The combined total cost of AIDS/HIV waiver services and Medicaid services shall not exceed the average cost of the member's level of care provided in a medical institution. The total monthly cost of AIDS/HIV waiver services cannot exceed $1,751 per month.

A Medicaid waiver service cannot be simultaneously reimbursed with another Medicaid waiver service or a Medicaid service. AIDS/HIV waiver services cannot be provided when the member is an inpatient of a medical institution.

AIDS/HIV Service Plan

Legal reference: 441 IAC 130.7(234), 83.47(249A)

A service plan must be developed before the onset of services and be reviewed on an annual basis thereafter or as necessary if service needs change. This plan must be completed as approved in ISIS before implementation of services.

All members shall have a service plan developed by a DHS service worker or case manager in cooperation with the member. The service plan for members **aged 20 or under** must be developed or reviewed taking into consideration all appropriate nonwaiver Medicaid services (such as Care for Kids), so as not to replace or duplicate those services.

See Service Plans for federal requirements for all home- and community-based services service plans. In addition to those federal requirements, the following service plan requirements also apply for the AIDS/HIV waiver:

- The service plan, both written and in ISIS, shall be completed every 12 months **or** when there is a significant change in a member's situation or condition.
- When consumer-directed attendant care is authorized, the services shall be provided as specifically delineated in the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372. This form must be given to the service worker or case manager before service can begin. A copy of the completed agreement shall be attached to the written version of the service plan.

If the member has a guardian or an attorney in fact under a durable power of attorney for health care, the written service plan shall address how consumer-directed attendant care services would be monitored to ensure the member's needs are adequately met.

Role of Ryan White CARE Act Programs

Although there are no statutory income restrictions for receiving CARE Act services, it is mandated that CARE Act programs be the payer of last resort. However, CARE Act funds can be used to pay for care provided to Medicaid members if:

- The state's Medicaid program does not cover a particular service benefit, or
- The member's service needs are greater than the amount of services available under Medicaid.

For example, CARE Act funds may be used to pay for additional nursing or home health aide service hours or visits beyond what is covered by Iowa Medicaid. CARE Act funds are never paid directly to the member but are paid to a provider on behalf of a member.

The Iowa state coordinator for Ryan White Part B can be reached at (515) 242-5316. Ryan White Part B AIDS/HIV Care and Support providers are listed as follows:

Mid-Iowa Community Action, Inc.
126 South Kellogg Ave, Suite 1
Ames, IA 50010
(515) 232-9020

AIDS Project of Central Iowa
711 East 2nd Street
Des Moines, IA 50309
(515) 284-0245

Linn County Aging and Disability Resource Center
800 1st Street SW
Cedar Rapids, IA 52405
(319) 892-5770

Dubuque Visiting Nurses Association
1454 Iowa Street, P.O. Box 359
Dubuque, IA 52004-0359
(800) 862-6133 or (563) 556-6200

AIDS Project Quad Cities
1351 West Central Park, Suite 320
Davenport, IA 52804
(563) 421-4241

Fort Dodge Area HIV/AIDS Coalition
Webster County Public Health
330 First Avenue North - Suite L2
Fort Dodge, IA 50501
(515) 573-4107

Iowa Center for AIDS Resources
and Education (ICARE) Services
438 Southgate Avenue
Iowa City, IA 52240
(319) 351-4357

University of IA HIV Program
Dept. of Internal Medicine,
SW34-GH
200 Hawkins Drive
Iowa City, IA 52242
(319) 384-7307

Mid-Iowa Community Action, Inc.
1001 S. 18th Ave
Marshalltown, IA 50158
(641) 752-7162

North Iowa Community Action, Inc.
300 15th NE
Mason City, IA 50401
(641) 423-8993

Nebraska AIDS Project
139 South 40th Street
Omaha, NE 68131
(402) 552-9260 or (800) 782-2437

Siouxland Community Health Center
1021 Nebraska Street
P.O. Box 5410
Sioux City, IA 51102
(712) 202-1027

Cedar Valley Hospice
Cedar AIDS Support System
2101 Kimball Ave, Suite 401
Waterloo, IA 50702 or
P.O. Box 2880
Waterloo, IA 50704
(319) 272-2002

AIDS/HIV Member Enrollment Process

Legal reference: 441 IAC 83.43(249A)

The following sequence describes the process for enrolling a member in the AIDS/HIV waiver program, including the actions of:

- The Department income maintenance worker (IM)
- The waiver slot manager (SM)
- The Department social work supervisor (SW SUP)
- The Department social work case manager (SW/CM)
- The Iowa Medicaid Enterprise Medical Services Unit (IME/MSU)

Stage / Actor	Description
1 IM	Receives request for application for AIDS/HIV services. Enters the case into the ABC system.
2 IM	Responds to query "Do you want to continue with waiver eligibility?" The IM worker normally responds by clicking the CONTINUE button on this milestone screen, unless certain that the applicant will not qualify financially or for some other obvious reason. If the response is negative, the process will not continue in ISIS, and the IM worker must deny the case in ABC. This allows a case to be denied before it is sent on to any other agent (such as IME). Gives the applicant the choice between waiver services and institutional services. ♦ If the applicant chooses facility care, denies the request for waiver eligibility on the ABC system. ♦ If the applicant chooses home- and community-based services, documents this in the case file.
3 IM	Responds to the ISIS milestone "What is the result of the disability determination?" NOTE: Disability determination is needed when the applicant's Medicaid eligibility is based on a disability. Disability determination is not needed when the Medicaid eligibility is based solely upon a coverage group that is not dependent on disability. Recommend pursuing a disability determination whenever there is a possible disability, but continue to process the application based on the other coverage group. If the response is "not disabled," the process ends here. No further milestones will be generated in ISIS. The IM worker makes entries in the ABC system to deny the waiver application. If the response is "disabled" or "not applicable," the process continues.
4 SM	Responds to the ISIS milestone "Is a slot available?" If a slot is available, refers the case to the service supervisor who was assigned via the ROLES screen. If a slot is not available, places the applicant on a waiting list.

Stage / Actor	Description
5 IM	If a slot is **not** available, responds to milestone "Slot is not available. Make entries in ABC." Denies the waiver application on the ABC system. ISIS will generate no further milestones.
6 IM	If a slot **is** available, gives form 470-4392, *Level of Care Certification for HCBS Waiver Program*, to the applicant to take to the applicant's physician.
7 SW Sup	Meets with the applicant to determine if any immediate needs must be addressed by referral to the appropriate resource. Coordinates completion of form 470-4392, *Level of Care Certification for HCBS Waiver Program*, and confirm that the assessment has been sent to Medical Services.
8 SW/CM	Responds to ISIS milestone "Complete assessment."
9 IM	If the application is withdrawn, denies the application in ABC.
10 SM	Updates the slot database.
11 SW/CM	Convenes the interdisciplinary team to determine necessary and appropriate services for the member. Obtains a release of information from the member or legal representative to share information with providers. Consumer choices options needs to be offered as a service choice. NOTE: A service plan may be developed while waiting on the level of care is being determined.
12 SW/CM	Develops the written service plan based on the interdisciplinary team meeting results, and enters the plan into ISIS as a proposed plan while waiting for level of care (LOC) determination and a level of care effective date. The ISIS service plan is created using the ISIS SERVICE PLAN screen and associated WAIVER SERVICES AGREEMENT WORKSHEET screen. (See 14-M for details on using these screens.)
13 IME/MSU	Responds to ISIS milestone "Determine assessment status." Allow reasonable time for form 470-4392, *Level of Care Certification for HCBS Waiver Program*, to reach IME. If the assessment is not received or is not complete, this milestone allows the IME Medical Services Unit to send the ISIS flow back to the service worker or case manager with instructions to complete the assessment.

Stage / Actor	Description
14 SW/CM	If applicable, responds to ISIS milestone "Assessment not received" by correcting any problem in delivering the assessment to IME and clicking "OK" on the milestone screen.
15 SW/CM	If received, responds to ISIS milestone "More information needed on assessment" by providing the require information and coordinating with the Medical Services Unit as necessary.
16 IME/MSU	If applicable, responds again to the ISIS milestone "Determine assessment status." This milestone and the social work case manager milestone must be repeated until the assessment is received and is complete.
17 IME	Responds to ISIS milestone "Select LOC, enter effective date and CSR date." Note that selection of "Denied" from the pull-down menu means that a valid level of care is not approved for this applicant.
18 IM/MSU	If received, responds to ISIS milestone "LOC has been denied, send NOD." Makes entries on ABC to deny the waiver application.
19 SM	If the level of care is denied, updates the database.
20 SW/CM	Watches for Medical Services Unit completion of level of care milestone (whether a new decision or a review). Responds to the ISIS milestone "Complete service plan entries" by completing the plan and adjusting dates as necessary to ensure that services don't start before the level of care effective date. NOTE: Do NOT respond positively to this milestone until you have actually entered the service plan into ISIS (using the ISIS SERVICE PLAN screen and associated WORKSHEET screens). Approval of the service plan is for the entire plan as defined, and not just for selected services.
21 SW/CM	If received, responds to ISIS milestone "LOC has been denied, send NOD, check for other services." NOTE: If level of care is denied, the process ends here. The next steps in this process assume that a valid level of care has been approved.

Stage / Actor	Description
22 IM	If the level of care decision is a change to the person's established level of care, receives and responds to ISIS milestone "Level of care has been set. Verify aid type is correct in ABC." Enters corrections into the ABC system as necessary.
23 SW/CM	Assures that the member and provider complete, sign, and date form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, when CDAC services are authorized. A copy of the completed form 470-3372 must be attached to and become part of the paper copy of the service plan. Each provider that may provide the CDAC service must complete, sign, and date a separate *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372. Assures that the member is made aware of the consumer choices option and assists in this process if the member chooses this option.
24 IM	Responds to ISIS milestone "Approval of Medicaid eligibility & facility/waiver services." A positive response gives final authorization for the program requested. If the waiver application is approved, verifies that the earliest of all three key dates (level of care date, financial eligibility date, and service start date) is chosen as the date of Medicaid eligibility.
25 IME/MSU	If the waiver application is not approved, receives and responds to the ISIS milestone "Medicaid eligibility &/or facility/waiver services have been denied." **or** If the waiver application is approved, receives and responds to the ISIS milestone "Medicaid eligibility & facility/waiver services have been approved. Send NOD, if applicable." The requirement to send a notice of decision will be a rare event.

Stage / Actor	Description
26 SW/CM	If the waiver application is **not** approved, receives and responds to the ISIS milestone "Medicaid eligibility &/or facility/waiver services have been denied. Send NOD. Check for other services." Sends form 470-0602, *Notice of Decision: Services*, denying waiver services to the applicant and the applicant's legal representative, if any. See Notice of Decision Completion for guidelines regarding information to be included. **or** If the waiver application **is** approved, receives and responds to the ISIS milestone "Medicaid eligibility & facility/waiver services have been approved. Send NOD, if applicable." Sends form 470-0602, *Notice of Decision: Services*, to the member and the member's legal representative, if applicable, and to the providers of services approving services. See Notice of Decision Completion for guidelines regarding information to be included on form 470-0602.
27 SW/CM	If the waiver application is approved, reviews the need for waiver services annually or when there is a significant change in the member's situation or condition.
28 SW/CM	Completes a service plan and level of care at least annually (both written and in ISIS).

Services Available Under the AIDS/HIV Waiver

Legal reference: 441 IAC 77.34(249A), 78.38(249A), 79.1(2), 83.46(249A)

AIDS/HIV services are individualized to meet the needs of each member. The following services are available:

- Adult day care
- Consumer choices option
- Consumer-directed attendant care (CDAC)
- Counseling services
- Home delivered meals
- Home health aide (HHA)
- Homemaker
- Nursing
- Respite

(For more information, see the *HCBS AIDS/HIV Waiver Services* Provider Manual.)

Brain Injury Waiver

Legal reference: 77.37(249A), 78.43(249A), 79.1(2), 79.1(15), Chapter 83 Division V

The Medicaid home- and community-based services brain injury waiver (HCBS BI) provides service funding and individualized supports to maintain eligible applicants in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost-effective.

The services that are considered necessary and appropriate for the applicant shall be determined through an interdisciplinary team consisting of the applicant, the Medicaid case manager, service providers, and other people the applicant chooses.

A designated number of members (payment slots) can be served under the HCBS BI program. Funding must be available either through the applicant's county of legal settlement or the state of Iowa based on individual level of care determination.

Assistance may be available through the rent subsidy program in addition to services available through the brain injury waiver. Applicants interested in applying for rent subsidy should contact the following address:

Iowa Finance Authority
HCBS Rent Subsidy Program
2015 Grand Ave.
Des Moines, IA 50312

The following sections explain:

- Waiver eligibility criteria
- The member enrollment process
- The services available under the waiver

BI Waiver Eligibility Criteria

Legal reference: 441 IAC 83.82(249A)

To be eligible for HCBS BI waiver services, an applicant must meet the following criteria:

- Have a diagnosis of brain injury.
- Be a U.S. citizen and Iowa resident.
- Be between the ages of 1 month and 64 years inclusive.
- Be determined eligible for Medicaid:
  - Under an SSI-related, or FMAP-related coverage group, or
  - Under special income level (300 percent group) consistent with a level of care in a medical institution.

  Waiver applicants may be Medicaid members before applying for waiver services or be determined eligible through the waiver application process. Medicaid eligibility may be available through the waiver program even if the applicant has previously been determined to be ineligible for Medicaid.
- Be determined by the Iowa Medicaid Enterprise (IME) Medical Services Unit to need one of the following levels of care:
  - Intermediate care facility for the intellectually disabled (ICF/ID)
  - Intermediate care facility (ICF)
  - Skilled nursing facility (SNF)
- Be determined by the IME Medical Services Unit to be able to live in a home- or community-based setting where all medically necessary service needs can be met by the BI waiver.

Conditions of BI Eligibility

Legal reference: 441 IAC 83.82(249A), 83.83(2)

The applicant must choose HCBS as an alternative to institutional services.

Applicants shall access all other services for which they are eligible and which are appropriate to meet their needs as a precondition of eligibility for the BI waiver. Following is the hierarchy for accessing waiver services:

- Private insurance
- Medicaid, including EPSDT (Care for Kids)
- BI waiver services
- In-home health-related care. (NOTE: This relationship is discussed further under consumer-directed attendant care. See Relationship to Other Services.)

Eligibility shall be effective as of the date when both the service eligibility and financial eligibility have been completed. BI waiver services provided before both approvals are obtained cannot be paid.

In order to receive BI waiver services, an approved BI waiver service provider must be available to provide those services. All BI waiver service providers must have training regarding or experience with people who have a brain injury.

A BI waiver member must need and use one of the available BI waiver services (in addition to case management) during each quarter of the calendar year. The total monthly cost of HCBS BI waiver services cannot exceed $2,812 per month.

A waiver service cannot be simultaneously reimbursed with another waiver service or Medicaid service. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services. BI waiver services cannot be provided when the member is an inpatient of a medical institution.

BI Service Plan

Legal reference: 441 IAC 83.87(249A)

A service plan must be developed and approved both in writing and in ISIS at the onset of services and reviewed on an annual basis thereafter or as necessary if service needs change.

All members will have a service plan developed and reviewed by a Medicaid case manager for the BI waiver in cooperation with the member. Refer to Service Plans for federal requirements for HCBS service plans. In addition, service plans for the HCBS BI waiver must be:

- Developed by the case manager for the BI waiver as identified by the county of residence.
- Based on service needs identified by an interdisciplinary team including the member and, if appropriate, legal representatives.
- Completed before service begins.
- Reviewed at least annually before expiration of current service plan.
- Be developed to reflect use of all appropriate nonwaiver Medicaid state services, so as to avoid duplication or replacement of services covered by those programs.

When **consumer-directed attendant care** is authorized, the services shall be provided as specifically delineated in the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372. A copy of this form must be given to the service worker or case manager before the service can begin. A copy of the completed agreement shall be attached to the paper version of the service plan.

If the member has a guardian or an attorney in fact under a durable power of attorney for health care, the written service plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are adequately met.

When **supported community living services** are included in the service plan, the plan must:

- Describe the living environments.
- List the number of hours of supervision needed.
- List the number of other HCBS members who will live with the member.
- Identify and justify any restrictions of member rights.

When a plan for a member aged 20 or under includes supported community living services beyond "intermittent," the Bureau of Long-Term Care designee must approve the plan. The plan will not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

The case manager must request the services beyond intermittent in writing and include:

- A summary of services and service costs, and
- A written justification of the rationale with sufficient information for the designee to evaluate the need for services beyond intermittent.

BI Member Enrollment Process

Legal reference: 441 IAC 83, Division V

The following sequence describes the process for enrolling a member in the brain injury (BI) waiver program, including the actions of:

- The Department income maintenance worker (IM)
- The waiver slot manager (SM)
- The case manager supervisor (CM SUP)
- The Medicaid case manager (CM)
- The Iowa Medicaid Enterprise Medical Services Reviewer (IME MS Reviewer)
- The Iowa Medicaid Enterprise Medical Services Prior Authorization Reviewer (MS PA Reviewer)
- The Department's medical arbitrator (MED ARB)
- The facility discharge planner (DP)

Stage / Actor	Description
1 IM	Receives request for application for HCBS BI services. The request may come from the discharge planner at a facility where the applicant is being discharged or from the applicant. Enters the case into the ABC system.
2 IM	Responds to the ISIS milestone "Do you want to continue with facility or waiver eligibility determination?" Clicks the CONTINUE button, unless certain that the applicant will not qualify financially or for some other obvious reason. As part of completing this milestone, assigns the service worker or case manager role to a social work or case management supervisor using the ISIS ROLES screen. If the milestone response is negative, denies the case in ABC. The process will not continue in ISIS. This allows a case to be ended before it is sent on to any other party (such as IME, MS PA Reviewer, or case management).
3 IM	Explains the choice between HCBS or institutional services to the applicant, the applicant's legal representative, or both. If the choice is for home- and community-based services, has the applicant or representative complete the section "Verification of HCBS Consumer Choice" on form 470-4694, *Case Management Comprehensive Assessment*. Forward this assessment tool to the designated supervisor. If the choice is for facility care, denies the request for waiver eligibility in ABC.
4 IM	Responds to the ISIS milestone "What is the result of the disability determination?" If the response is NOT DISABLED the process will end here. No further milestones will be generated in ISIS and the IM worker will need to make entries in ABC to "deny" the case. For brain injury cases, a disability determination is not required; therefore, the correct response on the milestone screen will always be DISABLED OR NOT APPLICABLE.

Stage / Actor	Description
5 SM	Responds to the ISIS milestone "Is a slot available?" If a slot is available, refers the case to the case management supervisor who was assigned via the ROLES screen. If slot is available and the applicant is diverted from the facility level of care, refers the case to the case management or service supervisor assigned via roles screen. If a slot is not available, places the applicant on the waiting list.
6 IM	If a slot is not available, responds to milestone "Slot is not available. Make entries in ABC." The IM worker should deny the waiver application in ABC at this point. ISIS will generate no further milestones.
7 CM SUP	If a slot is available, the case management supervisor responds to ISIS milestone "Referral for assignment." (If the case is reassigned to a case manager before the supervisor responds to this milestone, the milestone will appear on the worker's WORKLOAD screen. After the worker has responded, the ISIS STATUS screen will correctly reflect who has accepted the case. The remaining steps in this process description assume the supervisor has reassigned the case to a CM.) NOTE: In ISIS, the supervisor can assign cases to any subordinate worker or to another supervisor using the ISIS ROLES screen. Case managers can use the ROLES screen to reassign a case from themselves back to their supervisors. They cannot assign cases to anyone else.
8 CM	Coordinates with the discharge planner to assist the applicant with completion of form 470-4694, *Case Management Comprehensive Assessment*, and sends the form directly to IME for level of care determination and medical necessity assessment.
9 DP	Works with the applicant to complete form 470-4694, *Case Management Comprehensive Assessment*, submits it directly to IME, and notifies the CM.

Stage / Actor	Description
10 IM	If the application is withdrawn, denies application in ABC due to withdrawal of application. Slot manager updates the slot database. Responds to ISIS milestone "Determine assessment status." Allow reasonable time for the assessment to reach IME. If the assessment is not received or is not complete, this milestone allows the IME Medical Services Unit to send the ISIS flow back to the case manager with instructions to complete the assessment.
11 CM	Responds to ISIS milestone "Complete assessment."
12 CM	Convenes the interdisciplinary team to determine necessary and appropriate services for the applicant. Obtains a release of information from the applicant or legal representative to share information with providers. NOTE: A service plan may be developed while the level of care is being determined.
13 CM	Develops the written service plan based on the interdisciplinary team meeting results, and enters the plan into ISIS as a proposed plan while waiting for level of care (LOC) determination and a level of care effective date. The ISIS service plan is created using the ISIS SERVICE PLAN screen and associated WAIVER SERVICES AGREEMENT WORKSHEET screen. (See 14-M for details on using these screens.)
14 CM	When CDAC services are planned, assures that the applicant and the provider complete and sign form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*. A copy of the completed form 470-3372 must be attached to and become part of the paper copy of the service plan. Each provider that may provide the CDAC service must complete and sign a separate *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372.
15 CM	If applicable, responds to ISIS milestone "Assessment not received" by correcting any problem in delivering the assessment to IME and clicking "OK" on the milestone screen.

Stage / Actor	Description
16 CM	If received, responds to ISIS milestone "More information needed on assessment" by providing the required information and coordinating with IME as necessary.
17 IME/MSU	If applicable, responds again to the ISIS milestone "Determine assessment status." This milestone and the case management milestones must be repeated until the assessment is received and is complete.
18 IME/MSU	Responds to ISIS milestone "Select LOC, enter effective date and CSR date." Note that selection of "DENIED" from the pull-down menu means that none of the valid levels of care is approved for this applicant.
19 IM	If received, responds to ISIS milestone "LOC has been denied, send NOD." Makes entries on ABC to deny the waiver application.
20 CM	If received, responds to ISIS milestone "LOC has been denied, send NOD, check for other services." NOTE: If level of care is denied, the process ends here. The following steps in this process assume that a valid level of care has been approved.
21 IME	Responds to ISIS milestone "Is this consumer at an ICF/ID level of care?"
22 IME	If the applicant is not at an ICF/ID level of care, receives and responds to ISIS milestone "Is this consumer a minor or adult?" NOTE: The following five steps are for **adult** applicants.
23 IM	After county of legal settlement has been accepted or decided, receives and responds to ISIS milestone "Make county of legal settlement in ABC agree with county of legal settlement in ISIS." From this point onward, ISIS should always carry the correct assignment of county of legal settlement. The IM worker should not enter county of legal settlement changes in ABC except to make it match what is in ISIS. This ends the path that is exclusively for adults.

Stage / Actor	Description
24 CM	NOTE: The following steps are for both **adults** and **minors** except as noted. Responds to the ISIS milestone "Complete service plan entries" by completing the plan and adjusting dates as necessary to ensure services don't start before the level of care effective date. Do NOT respond positively to this milestone until you have actually entered the service plan into ISIS (using the ISIS SERVICE PLAN screen and associated WORKSHEET screens). NOTE: Approval of the service plan is for the entire plan as defined, and not just for selected services.
25 CM	Responds to the ISIS milestone "Was this an increase in service amounts? Or rates? Or the addition of new services?
26 MS PA Reviewer	Do you accept the service plan? Do units exceed maximum? Is this an increase from previous plan or new service?
27 CM	**Approve:** If the changes to the service plan have been authorized by the MS PA Reviewer, make changes to the service plan. Send an NOD. **Negotiate:** If the MS PA Reviewer requests changes to the service plan, the MS PA may call CM and a case conference may be held. Are the changes to the service plan complete? If an agreement is reached, the CM may then make changes to the service plan and send an NOD. **Deny:** If the MS PA Reviewer has denied, send an NOD, and check for other services.
28 IM	NOTE: The next steps are for **all** BI applicants. Responds to ISIS milestone "Level of care has been set. Verify aid type is correct in ABC." Enters corrections into the ABC system as necessary.
29 IM	Responds to ISIS milestone "Approval of Medicaid eligibility & facility/waiver services." A positive response gives final authorization for the program requested. If the BI waiver application is approved, verifies that the earliest of all three key dates (level of care date, financial eligibility date, and service start date) is chosen as the date of Medicaid eligibility.

Stage / Actor	Description
30 IME/MSR	If the BI waiver application is **not** approved receives and responds to the ISIS milestone "Medicaid eligibility &/or facility/waiver services have been denied." **or** If the BI waiver application **is** approved, receives and responds to the ISIS milestone "Medicaid eligibility & facility/waiver services have been approved. Send NOD, if applicable." The requirements to send a notice of decision will be a rare event.
31 CM	If the BI waiver application is **not** approved, receives and responds to the ISIS milestone "Medicaid eligibility &/or facility/waiver services have been denied. Send NOD. Check for other services." Sends a notice of decision denying waiver services to the applicant, the applicant's legal representative, or both. For guidelines on information to be included, see Notice of Decision Completion.
32 IME ME Reviewer	If the BI waiver application **is** approved, receives and responds to the ISIS milestone "Medicaid eligibility & facility/waiver services have been approved. Send NOD, if applicable." Sends a notice of decision approving services to the applicant, the applicant's legal representative, or both and the providers of services. See Notice of Decision Completion for guidelines on information to be included.
33 CM	If the BI waiver application is approved, reviews the need for waiver services annually or when there is a significant change in the member's situation or condition.
34 CM	Completes a service plan at least annually (both written and in ISIS).

Service Plan Authorization and Rate Changes

Legal reference: 441 IAC 79.1(2)

Case managers are responsible to receive service plan authorization whenever there is an increase in the amount of services, an increase in a service rate, or when a new service is added to a member's service plan. Service plan authorization workflow has been developed in ISIS to request, review, and authorize changes to a service plan. The service plan authorization workflow is started when changes are made to the member's service plan. See ISIS Service Plan Entries in the Procedures Common to All Waivers section of this manual.

Service Plan Authorization

The IME is responsible for authorization of all service plans for adults on the BI and ID waivers. Please note the following points related to service plan authorization for adult members on the BI and ID waivers:

- All service plan changes (units, rates, services, dates, etc.) will require the case manager to certify whether there was an increase to service unit amounts, service cost (rates), and services identified.
- Any increase in service unit amounts, service costs or the addition of a new service will trigger a new milestone in the Individualized Services Information System (ISIS) that will require service plan approval by the IME.
- The IME Prior Authorization (PA) reviewers will gather member details from ISIS, review assessment documentation, and may phone the CM or TCM for more information if necessary.
- Case managers should be prepared to answer questions related to the medical necessity of service plan changes.
- Information related to the service plan is reviewed by the IME.
- The IME staff will provide final authorization for the plan when it is determined that it meets the medical needs of the member.
- Waiver Prior Authorization (WPA) workflow for adults on the BI and ID waiver has been replaced with service plan authorization.
- The CM is no longer required to submit the WPA Certificate of Medical Necessity unless requested by the IME. The CM should be prepared to answer any or all questions that are in the Certificate of Medical Necessity.

As part of the service plan authorization, the IME will review and approve daily SCL rates (W1401). A case manager may enter three types of daily rates into a member's service plan based on the rate methodology used by the provider:

- Finalized cost report rates,
- Projected site rates using Schedule D-4, or
- Individual rates using a Schedule D-4.

Finalized Cost Report Rates

A provider is required to annually submit a cost report including all SCL daily site rates (W1300) with the IME Provider Cost Audit (PCA) unit. The cost report process requires a provider to submit financial information to support the costs associated with each site where SCL services are provided.

Upon review and finalization of the cost report, the IME PCA unit will issue a letter to the provider that identifies the approved cost report rate for each site and the effective date for the rate.

If a provider chooses to use the finalized cost report site rate, a case manager will enter the rate into the member's service plan and follow the ISIS workflow for approval.

If finalized cost report site rates are used, there is no contact with an IME Medical Services reviewer. The service plan will be approved without further review. The case manager will send out a notice of decision approving the cost report rate.

The case manager will be required to have the supporting documentation from the provider to support the finalized cost report site rate in the member's service plan file.

The finalized cost report site rate will remain in effect for the SCL site until:

- The provider requests a different rate based on changing needs of the member's living in the home, or
- A new finalized cost report site rate is established through the year end cost report process.

If one or more members move out of the home during the year, the provider may choose to continue using the finalized cost report site rate for any new members moving into the home. If there is a need to establish a new site rate based on the changing needs of a member within the site, the provider must establish a new projected site rate through the IME PCA unit. Submit a site D-4 worksheet and individual D-4 worksheets for each member in the site as identified above.

Projected Site Rates

When a provider establishes a new daily SCL site or requests a rate change for an existing daily SCL site, they must establish a new projected site rate with IME PCA.

The provider must submit a site D-4 worksheet and individual D-4 worksheet for each member in the site to IME PCA for review and approval.

Once received, the IME PCA unit, in conjunction with the IME Medical Services reviewer, will review the site D-4 worksheet, individual D-4 worksheets, and service plan to determine medical necessity and establish a new projected site rate.

The IME PCA will send the provider both the approved individual D-4 rates for all members in the home and the new approved projected site rate.

The provider may choose to use either of the rates, but must use either the individual rates **or** the projected site rate. A provider may not use a combination of the individual and site rates within the site.

The case manager will be required to have the supporting documentation from the provider to support the approved projected site rate in the member's service plan file.

If a provider chooses to use the approved projected site rate, a case manager will enter the rate into the member's service plan and follow the ISIS workflow for approval. If projected site rates are used, there is no contact with an IME Medical Services PA reviewer. The service plan will be approved without further review.

Projected site rates will remain in effect for the SCL site until:

- The provider requests a different rate based on changing needs of the member's living in the home, or
- A new cost report rate is established through the year end cost report.

If one or more members move out of the home during the year, the provider may choose to continue to use the projected site rate for any new members moving into the home. If there is a need to establish a new site rate based on the changing needs of a member within the site, the provider must establish a new projected site rate through the IME PCA unit. Submit a site D-4 worksheet and individual D-4 worksheet for each member in the site as identified above.

Individual D-4 Site Rates

If a provider chooses to use the approved individual D-4 rate, the case manager will enter the rate into the member's service plan and follow the ISIS workflow for approval. If the individual member's rate increase is based on a change in the member's need, the ISIS workflow will prompt the case manager to have supporting information available on the need for the change. The IME Medical Services PA Reviewer may be in contact to determine the need for the change is service.

If the increase in an individual rate is not based on a change in need of the member and is caused by a change in need of a roommate, the ISIS workflow will prompt the case manager to approve the plan. The service plan will be approved without further review by the IME. The case manager will be required to have the supporting documentation from the provider to support the individual rate in the member's service plan file.

Individual D-4 rates will remain in effect until there is a service needs change for **any** member living in the home that requires a new rate to be established.

When a change is needed, the provider must submit the site D-4 worksheet and individual D-4 worksheets to the IME PCA unit for all individuals living within the home and the site daily rate worksheet to establish new individual rates. The provider must send the new individual D-4 rates to all case managers to enter the new rate into the member's service plan. The case manager will follow the ISIS workflow to approve the new rates.

A provider may change the rate methodology used at any time by submitting the new rate and supporting documentation to the case manager for entry into the member's service plan.

SCL Daily Rate Plan Approval Process for Case Managers

Event	Actions/Response
Receives daily site rate from provider	CM enters the new rate into service plan and follows ISIS prompts. CM must determine the rate type used by the provider and respond accordingly in ISIS. The provider will submit information to the case manager to support the rate change request. The following actions are taken by the CM based on the event.
Receive a decrease in the daily site rate	Enter the rate into ISIS and follow the milestone prompt to approve the plan. No IME Medical Services PA review is required. Send NOD to provider.
Receive a new finalized cost report site rate	Providers are required to submit year end cost reports to IME PCA unit annually. A provider receives a new finalized cost report site rate from IME PCA based on the year end cost report. The provider will submit a copy of the finalized cost report site rate sheet sent to them by IME PCA for the site in which the member resides. Enter the finalized cost report site rate into ISIS and follow the milestone prompt to approve the plan. No IME Medical Services PA review is required. Send NOD to provider.
Receives an existing finalized cost report site rate	This rate is used when one member moves out of a site and a new member moves into a site that is using a finalized cost report site rate. The provider may choose to use the existing finalized cost report rate for the member moving into the site. The provider will submit a copy of the finalized cost report site rate sheet sent to them by IME PCA for the site in which the member resides. Enter the existing finalized cost report site rate into ISIS and follow the milestone prompt to approve the plan. No IME Medical Services PA review is required. Send NOD to provider.

Event	Actions/Response
Receives new projected site rate	This rate is used when a brand new site is developed by the provider or when a provider develops a new projected site rate due to changing needs of members living in the site. Enter the projected rate into ISIS and follow the milestone prompt to approve the plan. No further IME Medical Services PA review is required. Send NOD to provider. NOTE: Individual D-4 worksheets will have been previously reviewed and approved by the CM before receiving the request to use a new projected site rate.
Receives existing projected site rate	This rate is used when one member moves out of a site and a new member moves into a site that is using a projected site rate. The provider may choose to use the existing projected site rate for the member moving into the site. The provider will submit a copy of the projected rate sheet sent to them by IME PCA for the site. Enter rate into ISIS and follow the milestone prompt to approve the plan. No IME Medical Services PA review is required. Send NOD to provider.
Receives individual D-4 rate from the provider	This rate is used when a provider chooses to use the individual D-4 rate for the member. Provider will submit a copy of the individual D-4 schedule approved by the IME PCA for the member. Enter rate into ISIS and follow the milestone prompt to approve the plan. No IME Medical Services PA review is required. Send NOD to provider.

Event	Actions/Response
Receives an individual D-4 worksheet from provider	Reviews pages 2 & 3 of the submitted individual D-4 worksheet and signs off when the service needs of the member are identified in the projected rate developed by the provider. The individual D-4 worksheet will be received when: ♦ A new site is being developed. ♦ A new site rate is being developed based on a change in need of a member living within the site. NOTE: A CM will only receive and review a D-4 schedule of the member with the service needs change. If the site rate is changing due to the needs of others in the home, the CM will only receive the new projected rate from the provider with a note stating the rate change is due to the change in needs of others in the site.
Signs the individual D-4 worksheet	Sends signed individual D-4 worksheet back to provider. Keeps documentation to support the individual D-4. May receive a phone call from the IME Medical Services PA Reviewer with questions about the service needs of the member.
Receives call from IME Med Services PA Reviewer	Be prepared to communicate the member's needs to Med Services PA reviewer. The CM should have enough information to support the need for the amount of service in the plan to support the requested rate.

Services Available Under the BI Waiver

Legal reference: 441 IAC 77.39(249A), 78.43(249A), 83.86(249A)

BI waiver services are individualized to meet the needs of each member. The following services are available:

- Adult day care
- Behavioral programming
- Case management
- Consumer choices option
- Consumer-directed attendant care (CDAC)
- Family counseling and training
- Home and vehicle modifications (HVM)
- Interim medical monitoring and treatment (IMMT)
- Personal emergency response system (PERS)
- Prevocational services
- Respite
- Specialized medical equipment
- Supported community living (SCL)
- Supported employment (SE)
- Transportation

Children's Mental Health Waiver

Legal reference: 441 IAC 79.1(2), 79.1(15), 83.122

The Medicaid children's mental health waiver (CMH) provides service funding and individualized supports to maintain eligible children in their own homes or communities who would otherwise **require care in a medical institution.** Provision of **these services** must be cost effective.

The services that are considered necessary and appropriate for the child will be determined through an interdisciplinary team. The team shall consist of the child, the child's parent or guardian, the DHS service worker, service providers and other people the family chooses. A designated number of members (payment slots) can be served under the CMH waiver.

CMH Waiver Eligibility Criteria

Legal reference: 441 IAC 83.122

To be eligible for children's mental health waiver services, an applicant must meet all of the following requirements:

- The applicant must be under 18 years of age.
- The applicant must be diagnosed with a serious emotional disturbance.
  - **Initial certification.** For initial application to the CMH waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.
  - **Ongoing certification.** A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.
  - **Level of care.** The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The Iowa Medicaid Enterprise (IME) Medical Services Unit shall certify the applicant's level of care annually based on form 470-4694, *Case Management Comprehensive Assessment*.

- Financial eligibility. The applicant must be eligible for Medicaid as follows:
  - Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group; or
  - Be eligible under the special income level (300 percent) coverage group; or
  - Become eligible through application of the institutional deeming rules; or
  - Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.
- The applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on form 470-4694, *Case Management Comprehensive Assessment*.

CMH Service Plan

Legal reference: 441 IAC 83.122(6)

The applicant must have service needs that can be met under the children's mental health waiver program, as documented in the service plan. The applicant must be a recipient of targeted case management services or be identified to receive targeted case management services immediately following waiver enrollment.

All children's mental health waiver services shall be provided in accordance with the following standards:

- Services must be based on the child's needs as identified in the child's service plan.
- Services must be delivered in the least restrictive environment consistent with the child's needs.
- Payment for services shall be made only upon Departmental approval of the services. Waiver services provided before approval of the child's eligibility for the waiver shall not be paid.
- Services or service components must not be duplicative.

The total cost of children's mental health waiver services needed to meet the applicant's needs may not exceed $1,818 per month.

At a minimum, each CMH waiver member must receive one billable unit of a children's mental health waiver service per calendar quarter.

A child may be enrolled in only one HCBS waiver program at a time. A child may not receive children's mental health waiver services and family foster care services at the same time.

Reimbursement shall not be:

- Available under the waiver for any services that the member may obtain through the Iowa Medicaid program outside of the waiver.
- Available under the waiver for any services that the member may obtain through natural supports or community resources.
- Made simultaneously for the same period as nonwaiver Medicaid services or other Medicaid waiver services.

Costs for waiver services are not reimbursable while the member is in a medical institution.

CMH Member Enrollment Process

Legal reference: 441 IAC 83.123(249A)

The following sequence describes the process for enrolling a member in the CMH waiver program, including the actions of:

- The Department income maintenance worker (IM)
- The waiver slot manager (SM)
- The case manager supervisor (CM SUP)
- The medicaid case manager (CM)
- The Iowa Medicaid Enterprise Medical Services Unit (IME/MSU)

Stage / Actor	Description
1 IM	Receives request for application for HCBS CMH services. Enters the case into the ABC system.
2 IM	Responds to the ISIS milestone "Do you want to continue with facility or waiver eligibility determination?" Clicks the CONTINUE button, unless certain that the child will not qualify financially or for some other obvious reason. Assigns a CM supervisor using the ISIS ROLES screen. If the milestone response is negative, denies the case in ABC. The process will not continue in ISIS. This allows a case to be ended before it is sent on to anyone else (such as the IME Medical Services Unit).
3 IM	Explains to the child and the child's parents or legal guardian the choice between HCBS or institutional services. The child's parents or legal guardian must sign Part A, "Verification of HCBS Consumer Choice," on form 470-4694, *Case Management Comprehensive Assessment*, to document this choice. If the choice is HCBS services, files page 1 of the waiver assessment that contains the original authorized signature on Part A, "Verification of HCBS Consumer Choice," in the child's case file. If the choice is facility care, denies the request for waiver eligibility in ABC.
4 SM	Responds to the ISIS milestone "Is a slot available?" If the response is "AVAILABLE," the case is referred to the CM supervisor who assigned via the ROLES screen and to the IME Medical Services Unit.
5 IM	If a slot is not available, responds to milestone, "Slot is not available. Make entries in ABC." Denies the member's waiver application in ABC at this point. The process ends here. No further milestones are generated in ISIS.

Stage / Actor	Description
6 CM SUP	Responds to ISIS milestone "Referral for assignment." (Reassigning the case to a CM makes this milestone appear on the worker's WORKLOAD screen. After the worker has responded, the ISIS STATUS screen for this case will correctly reflect who has accepted the case.) The remaining steps in this process description assume the supervisor has reassigned the case to a CM. NOTE: In ISIS, the supervisor can assign cases to any subordinate worker using the ISIS ROLES screen. Service workers and case managers can use the ROLES screen to reassign a case back to a supervisor. They cannot assign cases to anyone else.
7 IME/MSU	Responds to ISIS milestone "Complete assessment."
8 CM	Convenes the interdisciplinary team to determine necessary and appropriate services for the child. Obtains a release of information from the child's parents or legal guardian to share information with providers. NOTE: A service plan may be developed while the level of care is being determined.
9 CM	Develops the written service plan based on the interdisciplinary team meeting results. Enters the plan into ISIS as a proposed plan while waiting for level of care (LOC) determination and a level of care effective date. The ISIS service plan is created using the ISIS SERVICE PLAN screen and associated WAIVER SERVICES AGREEMENT WORKSHEET screen. (See 14-M for details on using these screens.)
10 IME/MSU	Responds to ISIS milestone "Select LOC, enter effective date and CSR date." Selection of "Denied" means that a valid level of care has not been approved for this applicant. When "Denied" is selected, steps 11 and 12 follow. When "Physician Review" is selected, milestone returns to step 10 and is held there until the physician review is complete. Selection of "OK" continues to step 13.

Stage / Actor	Description
11 IM	If received, responds to ISIS milestone "LOC has been denied, send NOD." Makes entries on ABC to deny the waiver application.
12 CM	If received, responds to ISIS milestone "LOC has been denied, send NOD, check for other services." NOTE: If level of care is denied, the process ends here. The next steps in this process assume that a valid level of care has been approved.
13 IM	Responds to ISIS milestone "Level of care has been set. Verify aid type is correct in ABC." Enters corrections into the ABC system as necessary.
14 CM	Watches for completion of level of care milestone by the IME Medical Services Unit. Responds to the ISIS milestone "Complete service plan entries" by completing the plan and adjusting dates as necessary to ensure services don't start before the level of care effective date. Do **not** respond positively to this milestone until you have actually entered the service plan into ISIS using the ISIS SERVICE PLAN screen and associated WORKSHEET screens. NOTE: Approval of the service plan is for the entire plan as defined, not just for selected services.
15 IM	Responds to ISIS milestone "Approval of Medicaid eligibility & facility/waiver services." A positive response gives final authorization for the program requested. If the CMH waiver application is approved, verifies that the earliest of all three key dates (level of care date, financial eligibility date, and service start date) is chosen as the date of Medicaid eligibility.
16 IME/MSU	If the CMH waiver application is **not** approved, receives and responds to the ISIS milestone "Medicaid eligibility &/or facility/waiver services have been denied." **or** If the CMH waiver application **is** approved, receives and responds to the ISIS milestone "Medicaid eligibility & facility/waiver services have been approved. Send NOD, if applicable." The requirement to send a notice of decision will be a rare event.

Stage / Actor	Description
17 CM	If the CMH waiver application is **not** approved, receives and responds to the ISIS milestone "Medicaid eligibility &/or facility/waiver services have been denied. Send NOD. Check for other services." Sends a notice of decision to the child's parents or legal guardians denying waiver services. For guidelines regarding information to be included, see Notice of Decision Completion. **or** If the CMH waiver application **is** approved, receives and responds to the ISIS milestone "Medicaid eligibility & facility/waiver services have been approved. Send NOD, if applicable." Sends a notice of decision to the child's parents or legal guardians and the providers of services approving services. See Notice of Decision Completion, for guidelines regarding information to be included.

Services Available Under the CMH Waiver

Legal reference: 441 IAC 78.52

Children's mental health waiver services are individualized to meet the needs of each member. The following services are available under the CMH waiver:

- Environmental modifications and adaptive devices
- Family and community support services
- In-home family therapy
- Respite care services

Elderly Waiver

Legal reference: 441 IAC 77.33(249A), 78.37(249A), 79.1(2), 79.1(15), Chapter 83 Division II

The Medicaid home- and community-based services (HCBS) elderly waiver provides service funding and individualized supports to maintain eligible applicants in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective.

The services that are considered necessary and appropriate for the applicant will be determined through an interdisciplinary team consisting of:

- The applicant
- The elderly waiver case manager
- Service providers
- The guardian (if any)
- Other people the member chooses

Applicants may be eligible for assistance through the rent subsidy program in addition to services available through the elderly waiver. Applicants interested in applying for rent subsidy should contact the following address:

Iowa Finance Authority
HCBS Rent Subsidy Program
2015 Grand Ave.
Des Moines, IA 50312

The following sections explain:

- Waiver eligibility criteria
- The member enrollment process
- The services available under the waiver

Elderly Waiver Eligibility Criteria

Legal reference: 441 IAC 83.22(1)

Applicants who meet the following criteria may be eligible for HCBS elderly waiver services:

- Be 65 years of age or older.
- Be an Iowa resident.
- Be determined by the Iowa Medicaid Enterprise (IME) Medical Services Unit to need nursing or skilled level of care.
- Be eligible for Medicaid as if the applicant was in a medical institution.

Waiver applicants may be Medicaid members before accessing waiver services or may be determined eligible through the waiver application process. Medicaid eligibility may be available through the waiver program even if the applicant has previously been determined to be ineligible for Medicaid.

When a husband and wife who are living together both apply for the waiver, apply the income and resource guidelines as specified at 8-I, Income and Resources of Married Persons.

Conditions of Elderly Waiver Eligibility

Legal reference: 441 IAC 83.22(249A), 83.28(2)

As a precondition of eligibility for the elderly waiver, the applicant must:

- Receive case management services.
- Choose HCBS as an alternative to institutional services.
- Access all other services for which the applicant is eligible and which are appropriate to meet the member's needs.

Following is the hierarchy for accessing waiver services:

- Private insurance
- Medicaid
- Elderly waiver services
- In-home health-related care. (NOTE: This relationship is discussed further under consumer-directed attendant care. See Relationship to Other Services.)

The "gatekeeper" service requirement states that the applicant must need and use one billable elderly waiver service during each quarter of the calendar year.

The total costs of elderly waiver services cannot exceed the following:

- Nursing level of care $1,300.00 per month
- Skilled level of care $2,631.00 per month

In order for an applicant to receive elderly waiver services, an approved elderly waiver service provider must be available to provide those services.

Medicaid waiver service cannot be simultaneously reimbursed with another Medicaid waiver service or a Medicaid service. Elderly waiver services cannot be provided when a person is an inpatient of a medical institution.

Elderly Waiver Service Plan

Legal reference: 441 IAC 83.27(249A)

All applicants shall have a service plan developed by a case manager in cooperation with the member, using form 470-0563, *Individual Client Service Plan*, or an equivalent.

The service plan must be approved both in writing and on ISIS at the onset of services and reviewed on an annual basis thereafter or as necessary if service needs change. The service plan must be approved in ISIS before implementation of services.

When consumer-directed attendant care services are authorized, the services shall be provided as specifically delineated in the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372. A copy of this form must be given to the service worker or case manager before the service can begin. A copy of the completed form 470-3372 shall be attached to the printed service plan.

If the applicant has a guardian, the written service plan shall address how consumer-directed attendant care services will be monitored to ensure the applicant's needs are adequately met.

See Service Plans for federal requirements for HCBS service plans.

Elderly Waiver Member Enrollment Process

The following sequence describes the process for enrolling an applicant in the elderly waiver program, including the actions of:

- The income maintenance worker (IM)
- The waiver slot manager (SM)
- The case manager supervisor (CM SUP)
- The elderly waiver case manager (CM)
- The Iowa Medicaid Enterprise Medical Services Unit (IME/MSU)

Stage / Actor	Description
1 IM	Receives request for application for HCBS elderly waiver services. Enters the case into the ABC system.
2 IM	Responds to the ISIS milestone "Do you want to continue with waiver eligibility determination? The IM worker would normally respond by clicking the CONTINUE button on this milestone screen, unless certain that the applicant will not qualify financially or for some other obvious reason. If the applicant chooses institutional services, denies the cased in ABC. The process will not continue in ISIS. This allows a case to be denied before it is sent on to any other party (such as IME). If the applicant chooses waiver services, documents this choice in the case file.
3 IM	Requests a slot for the elderly waiver in ISIS.
4 SM	Responds to the ISIS milestone "Is there a slot available?" If a slot is available, the case is referred to the case manager supervisor who was assigned via the ROLES screen.
5 IM	If slot is not available, makes entries to deny in ABC system and sends a notice of decision to the applicant denying the waiver and explaining that the applicant is being placed on a waiting list for the waiver. ISIS will generate no further milestones.

Stage / Actor	Description
6 CM SUP	Responds to ISIS milestone "Referral for assignment." (If the case is reassigned to a case manager before the supervisor responds to this milestone the milestone will appear on the worker's WORKLOAD screen. After the supervisor has responded, the ISIS STATUS screen will correctly reflect who has accepted this case.) NOTE: In ISIS, the supervisor can assign cases to any subordinate worker or to another supervisor using the ISIS ROLES screen. Case managers can reassign cases back to their supervisors. They cannot assign cases to anyone else. The remaining steps in this process description assume the supervisor has reassigned the case to a case manager.
7 CM	Assures that the applicant is made aware of the consumer choices option available under the elderly waiver and assists in this process if the applicant chooses this option.
8 CM	Gives the applicant or representative form 470-4392, *Level of Care Certification for HCBS Waiver Program,* to take to the applicant's physician. Follows up with the physician to see that the form is sent to the Medical Service Unit.
9 CM	Convenes the interdisciplinary team to determine necessary and appropriate services for the member. Obtains a release of information from the applicant or legal representative in order to share information with providers. NOTE: A service plan may be developed with the level of care is being determined.
10 CM	Develops the written service plan based on the interdisciplinary team meeting results, and enters the plan into ISIS as a proposed plan while waiting for LOC determination and LOC effective date. Service should not start until LOC has been determined. This ISIS service plan is created using the ISIS SERVICE PLAN screen and associated WAIVER SERVICES AGREEMENT WORKSHEET screen. (See 14-M for details on using these screens.)

Stage / Actor	Description
11 CM	If applicable, responds to ISIS milestone "Assessment not received" by correcting any problem in delivering the assessment to IME and clicking "OK" on the milestone screen. CM needs to review notes and subtract additional information if necessary.
12 CM	If received, responds to ISIS milestone "More information needed on assessment" by providing the required information and coordinating with IME as necessary. All information should be provided before the final level of care decision.
13 IME/MSU	Completes the level of care review. If the applicant meets an eligible level of care, selects the level and enters the effective date and CSR date. If the level of care is denied, sends notice to the CM.
14 CM	Watches for completion of level of care milestone by the IME Medical Services Unit. Responds to the ISIS milestone "Complete service plan entries" by completing the plan and adjusting dates as necessary to ensure services don't start before the level of care effective date. Do **not** respond positively to this milestone until you have actually entered the service plan into ISIS using the ISIS SERVICE PLAN screen and associated WORKSHEET screens. NOTE: Approval of the service plan is for the entire plan as defined, not just for selected services.
15 CM	Assures that the applicant and provider complete, sign, and date form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, when CDAC services are planned. Each provider that may provide the CDAC service must complete and sign a separate agreement. A copy of the completed form 470-3372 must be attached to and become part of the paper copy of the service plan.

Stage / Actor	Description
16 IM	If received, responds to ISIS milestone "LOC has been denied, send NOD." Makes entries on ABC to deny the waiver application. Responds to ISIS milestone "Approval of Medicaid eligibility & facility/waiver services." A positive response gives final authorization for the program requested. If the waiver application is approved, verifies that the earliest of all three key dates (level of care date, financial eligibility date, and service start date) is chosen as the date of Medicaid eligibility.
17 CM	If the waiver application is **not** approved, receives and responds to the ISIS milestone "Medicaid eligibility &/or facility/waiver services have been denied. Send NOD. Check for other services." Sends form 470-0602, *Notice of Decision: Services*, denying waiver services to the applicant and the applicant's legal representative, if applicable. See Notice of Decision Completion for guidelines regarding information to be included. **or** If the waiver application **is** approved, receives and responds to the ISIS milestone "Medicaid eligibility & facility/waiver services have been approved. Send NOD, if applicable." Sends form 470-0602, *Notice of Decision: Services*, approving services to the applicant and the applicant's legal representative, if applicable, and to the providers of services. See Notice of Decision Completion for guidelines on information to be included on the NOD.
18 CM	Reviews the need for the waiver services annually or when there is a significant change in the member's situation **or** condition.

Services Available Under the Elderly Waiver

Legal reference: 441 IAC 83.25(249A), 77.33(249A), 78.37(249A)

Elderly waiver services are individualized to meet the needs of each member. The following services are available under the HCBS elderly waiver:

- Adult day care
- Assisted living on-call
- Assistive devices
- Case management
- Chore services
- Consumer choices option
- Consumer-directed attendant care (CDAC)
- Home and vehicle modification (HVM)
- Home delivered meals
- Home health aide (HHA)
- Homemaker services
- Mental health outreach
- Nursing care
- Nutritional counseling
- Personal emergency response system
- Respite
- Senior companions
- Transportation

Health and Disability Waiver

Legal reference: 441 IAC 79.1(2), 79.1(15), 83.2(2)"a" and "b," 83.3(2), 83.6

The Medicaid home- and community-based services health and disability waiver (HCBS HD) provides service funding and individualized supports to maintain eligible applicants in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective.

The services that are considered necessary and appropriate for the applicant will be determined through an interdisciplinary team. The team shall consist of the applicant, the applicant's parent or guardian, the DHS service worker, service providers, an Iowa Child Health Specialty Clinics regional nurse (when children are involved) and other people the applicant chooses.

A designated number of members (payment slots) can be served under the HCBS HD program.

The health and disability waiver has an advisory committee that meets regularly to make recommendations and to ensure the waiver best meets the need of the people it serves.

Applicants may be eligible for assistance through the rent subsidy program in addition to services available through the health and disability waiver. Applicants interested in applying for rent subsidy should contact the following address:

Iowa Finance Authority
HCBS Rent Subsidy Program
2015 Grand Ave.
Des Moines, IA 50312

The following sections explain:

- Waiver eligibility criteria
- The member enrollment process
- The services available under the waiver

HD Waiver Eligibility Criteria

Legal reference: 441 IAC 83.2(1)

The health and disability waiver pays for services to blind or disabled people who otherwise would need care in a nursing facility, skilled nursing facility, or an intermediate care facility for people with an intellectual disability.

The waiver is administered jointly by the income maintenance and service units, in cooperation with the Iowa Medicaid Enterprise (IME) Medical Services Unit and the University of Iowa Child Health Specialty Clinics.

To be eligible for the health and disability waiver, an applicant must meet all of the following requirements:

- A payment slot must be available.
- The applicant must be either blind or disabled as determined through the receipt of social security disability benefits or through the Department's disability determination process. See 8-C, When the Department Follows an SSA Disability Determination.

  NOTE: People aged 65 or over are not eligible for the health and disability waiver. The elderly waiver is available statewide.
- The applicant must be ineligible for SSI if age 21 or older, except that people who are receiving health and disability waiver services upon reaching the age of 21 may continue to be eligible regardless of SSI eligibility until they reach the age of 25. See 8-N, Ineligibility for SSI.
- The applicant must meet the eligibility requirements for SSI-related Medicaid.
- The applicant must 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 a nursing facility, skilled nursing facility, or intermediate care facility for people with an intellectual disability.
- The applicant must have service needs that can be met by the health and disability HCBS program as determined by the sociak work case manager, the applicant, and the interdisciplinary team. At a minimum, a member must receive a unit of service per quarter.
- The applicant must have a written service plan completed annually.

Check with the Department social work case manager that the plan is in place at the time of the annual review. Sufficient details about the written service plan are entered into ISIS to enable tracking of the case and authorization for IME to make payments. This information in ISIS is also referenced as a service plan.

Conditions of HD Eligibility

The applicant must choose HCBS as an alternative to institutional services.

The applicant shall access all other services for which the applicant is eligible and which are appropriate to meet the applicant's needs as a precondition of eligibility for the health and disability waiver. Following is the hierarchy for accessing waiver services:

- Private insurance
- Medicaid, including EPSDT (Care for Kids)
- HD waiver services
- State Supplementary Assistance in-home health-related care. (NOTE: This relationship is discussed further under consumer-directed attendant care. Refer to Relationship to Other Services for further clarification.)

The total costs of health and disability waiver services cannot exceed the following:

- Nursing level of care $904.00 per month
- Skilled level of care $2,631.00 per month
- ICF/ID level of care $3,203.00 per month

In order to receive HD waiver services, an approved HD waiver service provider must be available to provide those services.

Health and disability waiver services cannot be provided when a person is an inpatient of a medical institution.

HD Service Plan

Legal reference: 441 IAC 83.7(249A), 130.7(234)

All applicants shall have a service plan developed by a DHS social work case manager in cooperation with the applicant. A service plan must be approved at the onset of services and reviewed on an annual basis thereafter (or more often, if service needs change). This plan must be completed in writing and be entered on ISIS before implementation of services.

See Service Plans for federal requirements for all HCBS service plans. In addition to the federal service plan requirements, following requirements also apply for the HCBS HD waiver:

- Service plans for applicants aged **20 or under** must be developed or reviewed taking into consideration those services that may be provided through the individual education plan (IEP) and EPSDT (Care for Kids) plans.

  The service plan should be developed after the IEP or EPSDT plan to avoid duplication or replacement of services covered by those programs.

- When consumer-directed attendant care is authorized, the services shall be provided as specifically delineated in the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372. A copy of this form must be given to the service worker or case manager before the service can begin. A copy of the completed agreement form shall be attached to the written service plan.

  If the applicant has a guardian, the written service plan shall address how consumer-directed attendant care services would be monitored to ensure the applicant's needs are adequately met.

- The service plan must be completed in writing and on ISIS every 12 months **or** when there is a significant change in a member's situation or condition.

HD Member Enrollment Process

Legal reference: 441 IAC 83.3(249A)

The following sequence describes the process for enrolling an applicant in the health and disability (HD) waiver program, including the roles of:

- The Department income maintenance worker (IM)
- The waiver slot manager (SM)
- The Department social work supervisor (SW SUP)
- The Department social work case manager (SW/CM)
- The Child Health Specialty Clinics (CHSC)
- The Iowa Medicaid Enterprise Medical Services Reviewer (IME MS Reviewer)
- The Iowa Medicaid Medical Service Prior Authorization Reviewer (PA MS Reviewer)

Stage / Actor	Description
1 IM	Receives request for application for HCBS health and disability services. Enters the case into the ABC system.
2 IM	Responds to the ISIS milestone "Do you want to continue with waiver eligibility?" The IM worker normally responds by clicking the CONTINUE button on this milestone screen, unless certain that the applicant will not qualify financially or for some other obvious reason. If the IM worker's response is negative, the process will not continue in ISIS, and the IM worker must deny the case in ABC. This allows a case to be denied before it is sent on to any other agency (such as IME). Gives the applicant the choice between waiver services and institutional services. ♦ If the choice is for facility care, the IM worker denies the request for waiver eligibility in ABC. ♦ If the choice is for home- and community-based services, IM will document this in the case file.

Stage / Actor	Description
3 IM	Responds to the ISIS milestone "What is the result of the disability determination?" NOTE: A disability determination is needed when the applicant's Medicaid eligibility is based on a disability. A disability determination is not needed when Medicaid eligibility is based solely upon another coverage group that is not dependent on disability. Recommend pursuing a disability determination whenever there is a possible disability, but continue to process the application based on the other coverage group. If the response is "DISABLED" or "NOT APPLICABLE," the process continues. If the response is "NOT DISABLED," the process ends here. No further milestones will be generated in ISIS. The IM worker makes entries in ABC to deny the waiver application.
4 SM	Responds to the ISIS milestone "Is a slot available?" If a slot is available, refers the case to the social work supervisor who was assigned via the ROLES screen. If a slot is not available, places the applicant on a waiting list.
5 IM	If the slot is not available, responds to milestone "Slot is not available. Make entries in ABC." Denies the waiver application in ABC. ISIS will generate no further milestones.
6 IM	If a slot is available, gives form 470-4392, *Level of Care Certification for HCBS Waiver Program*, to the applicant to take to the applicant's physician.
7 SW/CM	Meets with applicant to determine if there are any immediate needs that need to be addressed and refers to the appropriate resource.
8 SW/CM	Responds to ISIS milestone "Complete assessment." Coordinates completion of assessment and confirms assessment has been sent to the IME Medical Services Unit.
9 IM	If the application is withdrawn, denies the application in ABC.

Stage / Actor	Description
10 SM	Updates the slot database.
11 IM	Refers children under the age of 21 to Child Health Specialty Clinic.
12 SW/CM	Convenes the interdisciplinary team to determine necessary and appropriate services for the member. Obtains a release of information from the member or legal representative to share information with providers. Consumer choices options needs to be offered as a service choice. NOTE: A service plan may be developed while waiting on the level of care is being determined.
13 SW/CM	Develops the written service plan based on the interdisciplinary team meeting results, and enters the plan into ISIS as a proposed plan while waiting for level of care (LOC) determination and a level of care effective date. The ISIS service plan is created using the ISIS SERVICE PLAN screen and associated WAIVER SERVICES AGREEMENT WORKSHEET screen. (See 14-M for details on using these screens.)
14 IME/MSU Reviewer	Responds to ISIS milestone "Determine assessment status." Allow reasonable time for the assessment to reach IME. If the assessment is not received or is not complete, this milestone allows the IME Medical Services Reviewer to send the ISIS flow back to the service worker with instructions to complete the assessment.
15 SW/CM	If applicable, responds to ISIS milestone "Assessment not received" by correcting any problem in delivering the assessment to IME and clicking "OK" on the milestone screen.
16 SW/CM	If received, responds to ISIS milestone "More information needed on assessment" by providing the require information and coordinating with the Medical Services Unit as necessary.
17 IME/MSU	If applicable, responds again to the ISIS milestone "Determine assessment status." This milestone and the service worker or case manager milestone must be repeated until the assessment is received and is complete.
18 IME/MSU Reviewer	Responds to ISIS milestone "Select LOC, enter effective date and CSR date." Note that selection of "DENIED" from the pull-down menu means that a valid level of care is not approved for this member.

Stage / Actor	Description
19 IM	If the level of care is denied, responds to ISIS milestone "LOC has been denied, send NOD." Makes entries on ABC to deny the waiver application.
20 SM	If the level of care is denied, updates the slot database.
21 SW/CM	If the level of care is denied, responds to ISIS milestone "LOC has been denied, send NOD, check for other services." NOTE: The process ends here. The next steps in this process assume that a valid level of care has been approved.
22 IM	If the level of care selection is a change to the person's established level of care, receives and responds to ISIS milestone "Level of care has been set. Verify aid type is correct in ABC." Enters corrections into the ABC system as necessary.
23 SW/CM	Watches for completion of level of care milestone by the Medical Services Unit (whether a new level of care or a change to level of care). Responds to the ISIS milestone "Complete service plan entries" by completing the plan and adjusting dates as necessary to ensure that services don't start before the level of care effective date. Do not respond positively to this milestone until you have actually entered the service plan into ISIS (using the ISIS SERVICE PLAN screen and associated WORKSHEET screens). NOTE: Approval of the service plan is for the entire plan as defined, and not just for selected services.
24 SW/CM	Assures that the member and the provider complete, sign, and date form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, when CDAC services are authorized. Each provider that may provide the CDAC service must complete, sign, and date a separate agreement. A copy of the completed form 470-3372 must be attached to and become part of the paper copy of the service plan. Assures that the member is made aware of the consumer choices option available under the waiver and assists in this process if the member chooses this option.

Stage / Actor	Description
25 IM	Responds to ISIS milestone "Approval of Medicaid eligibility & facility/waiver services." A positive response gives final authorization for the program requested. If the waiver application is approved, verifies that the earliest of all three key dates (level of care date, financial eligibility date, and service start date) is chosen as the date of Medicaid eligibility.
26 IME/MSU Reviewer	If the waiver application is **not** approved, receives and responds to the ISIS milestone "Medicaid eligibility &/or facility/waiver services have been denied." **or** If the waiver application **is** approved, receives and responds to the ISIS milestone "Medicaid eligibility & facility/waiver services have been approved. Send NOD, if applicable." The requirement to send a notice of decision will be a rare event.
27 SW/CM	If the waiver application is **not** approved, receives and responds to the ISIS milestone "Medicaid eligibility &/or facility/waiver services have been denied. Send NOD. Check for other services." Sends form 470-0602, *Notice of Decision: Services*, denying waiver services to the applicant and the applicant's legal representative, if applicable. See Notice of Decision Completion for guidelines on information to be included. **or** If the waiver application **is** approved, receives and responds to the ISIS milestone "Medicaid eligibility & facility/waiver services have been approved. Send NOD, if applicable." Sends form 470-0602, *Notice of Decision: Services*, approving services to the member and the member's legal representative, if applicable, and the providers of services. See Notice of Decision Completion for guidelines on information to be included on the form.
28 SW/CM	If the waiver application is approved, reviews the need for waiver services annually or when there is a significant change in the person's situation or condition.
29 SW/CM	Completes a service plan and level of care at least annually (both written and in ISIS).

Child Health Specialty Clinics Process

The Department has entered into an agreement with the Child Health Specialty Clinics (CHSC) to define responsibilities of each party in the assessment, planning, and care coordination activities related to applicants and members of the health and disability waiver who are age 21 or under.

CHSC staff does not require a release of information when coordinating services for children under the HCBS health and disability waiver.

The Child Health Specialty Clinics are Iowa's statewide program for children and youth with special health care needs. CHSC generally does not provide services for acute illness or primary care for well child care.

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. Specialized child health services offered by Child Health Specialty Clinic 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 Child Health Specialty Clinic are made available through 13 regional child health centers, statewide mobile clinics conducted in local facilities, and CHSC's central office, located in Iowa City. For questions about these services, the phone number in Iowa City is 319-356-1469.

Address correspondence to Health Service Coordinator, Child Health Specialty Clinics, at the regional address. The locations, addresses, and phone numbers of the regional centers are listed on the "HCBS Contacts" link on the waiver Internet site:
http://www.ime.state.ia.us/HCBS/HCBSContacts.html

Services Available Under the HD Waiver

Legal reference: 441 IAC 83.6(249A), 77.30(249A), 78.34(249A)

Health and disability (HD) waiver services are individualized to meet the needs of each member. The following services are available under the HD waiver:

- Adult day care
- Consumer choices option
- Consumer-directed attendant care (CDAC)
- Counseling services
- Home and vehicle modification
- Home health aide (HHA)
- Home-delivered meals
- Homemaker
- Interim medical monitoring and treatment (IMMT)
- Nursing
- Nutritional counseling
- Personal emergency response
- Respite

Intellectual Disability Waiver

Legal reference: 441 IAC 77.37(249A), 78.41(249A), Chapter 83, Division IV

The Medicaid home- and community-based intellectual disability waiver (HCBS ID) provides service funding and individualized supports to maintain eligible applicants in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective.

The services that are considered necessary and appropriate for the applicant shall be determined through an interdisciplinary team consisting of the applicant, parent or guardian, DHS service worker or Medicaid case manager, service providers, and other people the applicant chooses.

The Iowa Medicaid Enterprise (IME) has designated the number of members (payment slots) that can be served under the HCBS ID waiver. Funding must be available through IME.

Assistance may be available through the in-home health-related care program and the rent subsidy program in addition to services available through the intellectual disability waiver. Applicants interested in applying for rent subsidy should contact the following address:

Iowa Finance Authority
HCBS Rent Subsidy Program
2015 Grand Ave.
Des Moines, IA 50312

The following sections explain:

- Waiver eligibility criteria
- The member enrollment process
- The services available under the waiver

ID Waiver Eligibility Criteria

Legal reference: 441 IAC 83.61(1)

To be eligible for HCBS ID waiver services, a person must meet the following criteria:

- Have an intellectual disability or, for residential-based supported community living services only, a diagnosis of a related condition, as defined. The diagnosis shall be initially established and recertified as follows:

Age	Initial Application to HCBS Intellectual Disability Waiver	Recertification: MODERATE, SEVERE, OR PROFOUND ID	Recertification: MILD OR UNSPECIFIED ID
0 through 17 years	Psychological documentation within **3** years of application date substantiating ID diagnosis (or for RBSCL, diagnosis of a related condition)	Substantiate ID diagnosis (or for RBSCL, diagnosis of a related condition): ♦ Every **6** years + ♦ Whenever a significant change occurs	Substantiate ID diagnosis (or for RBSCL, diagnosis of a related condition): ♦ Every **3** years ♦ Whenever a significant change occurs.
18 through 21 years	♦ Psychological documentation substantiating ID diagnosis within **3** years before application date; **or** ♦ Diagnosis of ID made before age 18 and current psychological documentation substantiating ID diagnosis	Psychological documentation substantiating ID diagnosis: ♦ Every **10** years ♦ Whenever a significant change occurs	Psychological documentation substantiating ID diagnosis: ♦ Every **3** years ♦ Whenever a significant change occurs.

Age	Initial Application to HCBS Intellectual Disability Waiver	Recertification: MODERATE, SEVERE, OR PROFOUND ID	Recertification: MILD OR UNSPECIFIED ID
22 years or over	Diagnosis of ID made before age 18 and current psychological documentation substantiating ID diagnosis if the last testing date was: ♦ More than **5** years ago if applicant's diagnosis is mild or unspecified ID, **or** ♦ More than **10** years ago if applicant's diagnosis is moderate, severe, or profound ID.	Psychological documentation substantiating ID diagnosis made since the member reached 18 years of age.	Psychological documentation substantiating ID diagnosis: ♦ Every **6** years ♦ Whenever a significant change occurs

- Be eligible for Medicaid under SSI-related or FMAP-related coverage groups or under the special income level (300%) coverage group, become eligible through application of the institutional deeming rules, or would be eligible if in a medical institution.

  Waiver applicants may be Medicaid members before accessing waiver services or may be determined eligible through the waiver application process. Medicaid eligibility may be available through the waiver program even if the applicant has previously been determined to be ineligible for Medicaid.

- Be determined by the Iowa Medicaid Enterprise (IME) Medical Services Unit to need intermediate care facility for people with an intellectual disability (ICF/ID) level of care.

- Be a recipient of the Medicaid MI/ID/DD case management services or be identified to receive case management services immediately following program enrollment. The member must receive Medicaid case management services when ID waiver services begin.

- Be assigned a payment slot through the Iowa Medicaid Enterprise. A payment slot must be available and assigned to the applicant at the time of application or after disability determination, whichever is later.

ID Waiver Slot Assignment

Legal reference: 441 IAC 83.61(4)

The Department uses the following process to assign payment slots for applicants for the HCBS intellectual disability waiver.

- A payment slot shall be assigned to the applicant upon confirmation of an available slot.
  - Once a payment slot is assigned, the Department shall give written notice to the applicant.
  - The Department shall hold the payment slot 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.
- If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. Effective October 1, 2011, the Department shall assess each applicant placed on the waiting list to determine the applicant's priority need.
  - Applicants who meet an **emergency** need criterion shall be placed on the priority waiting list based on the total number of criteria that are met.
  - Applicants who meet an **urgent** need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria.
  - If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list.
  - If the application date is the same, the older applicant shall be placed higher on the waiting list.
- Applicants shall remain on the waiting list until:
  - A payment slot has been assigned to them for use,
  - They withdraw from the list, or
  - They become ineligible for the waiver.

If there is a change in an applicant's need, the applicant may contact the Department local office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list.

- To maintain the approved number of members in the program, the Department shall select people from the waiting list as payment slots become available, based on their priority order on the waiting list.
  - Once a payment slot is assigned, the Department shall give written notice to the person within five working days.
  - The Department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

Emergency need criteria are as follows:

- The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.
- The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.
- The applicant is living in a homeless shelter and no alternative housing options are available.
- There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.
- The applicant cannot meet basic health and safety needs without immediate supports.

Urgent need criteria are as follows:

- The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.
- The caregiver will be unable to continue to provide care within the next 60 days.
- The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.
- The applicant is living in temporary housing and plans to move within 31 to 120 days.

- The applicant is losing permanent housing and plans to move within 31 to 120 days.
- The caregiver will be unable to be employed if services are not available.
- There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.
- The applicant has behaviors that put the applicant at risk.
- The applicant has behaviors that put others at risk.
- The applicant is at risk of facility placement when needs could be met through community-based services.

Conditions of ID Eligibility

Legal reference: 441 IAC 83.61(2)

The applicant must choose HCBS as an alternative to institutional services.

As a precondition of eligibility for the ID waiver, applicants shall access all other services for which they are eligible and that are appropriate to meet their needs. Following is the hierarchy for accessing waiver services:

- Private insurance
- Medicaid, including EPSDT (Care for Kids)
- ID waiver services
- In-home health-related care.

(NOTE: The relationship to State Supplementary Assistance is discussed further under consumer-directed attendant care. See Relationship to Other Services.)

The gatekeeper service requirement is that a member must need and use, at a minimum, one unit of service during each quarter of the calendar year.

In order for a person to receive ID waiver services, an approved ID waiver service provider must be available to provide those services.

Medicaid waiver service cannot be simultaneously reimbursed with another Medicaid waiver service or a Medicaid service. ID waiver services cannot be provided when a person is an inpatient of a medical institution.

ID Service Plan

Legal reference: 441 IAC 24.4(4), 83.67(249A)

All waiver applicants shall have a service plan developed by a DHS service worker or Medicaid case manager in cooperation with the applicant. The service plan must be:

- Developed at the onset of services. (The plan must be completed before services are implemented.)
- Reviewed on an annual basis thereafter or sooner if service needs change.

Refer to Service Plans for federal requirements for HCBS service plans. In addition to the federal requirements, the following are service plan requirements for the HCBS ID program:

- An interdisciplinary team must develop the plan.
- For people aged **20 or under,** the plan must be developed or reviewed taking into consideration services that may be provided through the individual education plan (IEP) and EPSDT (Care for Kids) plans (if applicable), to avoid duplication or replacement of services covered by those programs.
- The plan must be reviewed at least annually before current plan expires.
- When consumer-directed attendant care (CDAC) is authorized, the services shall be provided as specifically stated in form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*. A copy of this form must be given to the service worker or case manager before the service can begin. Attach a copy of the completed agreement to the service plan.

  If the applicant has a guardian, the service plan shall address how CDAC services will be monitored to ensure that the member's needs are adequately met.
- When supported community living services are included in the plan, also:
  - Describe the living environments.
  - List the number of hours of supervision needed.
  - List the number of other HCBS members who will live with the member.
  - Identify and justify any restrictions of member rights.

ID Member Enrollment Process

Legal reference: 441 IAC 83.61(2), 83.61(4), 83.62(249A), 83.66(249A), 83.67(249A), 83.68(249A)

The following sequence describes the process for enrolling an applicant in the ID waiver, including the actions of:

- The income maintenance worker (IM)
- The medical arbitrator (MED ARB)
- The waiver slot manager (SM)
- The social work or Medicaid case manager (SW/CM)
- The service worker or case manager supervisor (SW/CM SUP)
- The Iowa Medicaid Enterprise Medical Services Reviewer (IME MS Reviewer)
- The Iowa Medicaid Enterprise Medical Services Prior Authorization Reviewer (MS PA Reviewer)

Stage / Actor	Description
1 IM	Receives request for application for HCBS ID services. Enters the case into the ABC system with the probable county of legal settlement. (The official county of legal settlement is decided later in the process.)
2 IM	Responds to the ISIS milestone "Do you want to continue with waiver eligibility?" The IM worker normally responds by clicking the CONTINUE button on this milestone screen, unless certain that the applicant will not qualify financially or for some other obvious reason. As part of completing this milestone, assigns the service worker or case manager role to a service or case management supervisor using the ISIS ROLES screen. ♦ Refers adults who are currently Medicaid members to a Medicaid case manager supervisor. ♦ For children and for adults who are not yet Medicaid-eligible, refers the applicant to a Department service worker supervisor. If the response is negative, the process will not continue in ISIS; worker denies the application in ABC. This allows a case to be denied before it is sent on to any other party (such as IME, central point of coordination, or case management).

Stage / Actor	Description
3 IM	Explains to the applicant, the applicant's legal representative, or both the choice between HCBS or institutional services. If the choice is for facility care, denies the request for waiver eligibility in ABC. If the choice is for home- and community-based services, has the applicant or representative complete the section "Verification of HCBS Consumer Choice," on form 470-4694, *Case Management Comprehensive Assessment*. Forwards the assessment form to the designated service worker or case manager.
4 IM	Responds to the ISIS milestone "What is the result of the disability determination?" NOTE: A disability determination is needed when the applicant's Medicaid eligibility is based on a disability. Disability determination is not necessary when the Medicaid eligibility is based solely upon a coverage group that is not dependent on disability. Recommend pursuing a disability determination whenever there is a possible disability, but continue to process the application based on the other coverage group. If the response is "not disabled," the process ends here. No further milestones will be generated in ISIS. The IM worker makes entries in ABC to deny the waiver application. If the response is "disabled" or "not applicable," the process continues.
5 IM	After county of legal settlement has been accepted or decided, receives and responds to ISIS milestone "Make county of legal settlement in ABC agree with county of legal settlement in ISIS." From this point onward, ISIS should always carry the correct assignment of county of legal settlement. The IM worker should not change county of legal settlement in ABC except to make it match ISIS. This ends the path that is exclusively for adults.

Stage / Actor	Description
6 Slot manager or CPC	Responds to the ISIS milestone "Is a slot available?" If the response is "available," the case is referred to the service or case management supervisor who was assigned via the ROLES screen. **Note to service worker or case manager:** The Medicaid case manager will coordinate the enrollment process for Medicaid eligible adults. The DHS service worker will coordinate the enrollment process for adults not yet Medicaid-eligible and for all children. Adults may be referred to Medicaid case management upon Medicaid eligibility determination. Children will be referred to Medicaid case management immediately following waiver enrollment.
7 IM	If a slot is not available, IM responds to milestone, "Slot is not available make entries in ABC." The IM should deny the consumer in the ABC system at this time.
8 SW/CM SUP	If the member is an adult, receives and responds to ISIS milestone "Referral for assignment." (Consider reassigning this case to a service worker or case manager before responding to this milestone. This milestone would then appear on the worker's WORKLOAD screen, and after the worker has responded, the ISIS STATUS screen for this case would correctly reflect who has accepted the case.) The remaining steps in this process description assume the supervisor has reassigned the case to a service worker or case manager. NOTE: In ISIS, the supervisor can assign cases to any subordinate worker, using the ISIS ROLES screen. Service workers and case managers can use the ROLES screen to reassign a case from themselves back to their supervisors. They cannot assign cases to anyone else.
9 SW/CM	Completes form 470-4694, *Case Management Comprehensive Assessment.*

Stage / Actor	Description
10 SW/CM	Sends completed form 470-4694, *Case Management Comprehensive Assessment*, and documentation of level of functioning to the IME Medical Services Unit. Include the following: ♦ Documentation for adults must have an intellectual disability using a recognized diagnosis tool. ♦ Documentation for children aged five or under is a statement from a psychologist indicating the child is functioning with an intellectual disability.
11 SW/CM	Responds to ISIS milestone "Complete assessment."
12 IME MS Reviewer	Responds to ISIS milestone "Determine assessment status." Allow reasonable time for the assessment to reach IME. If the assessment is not received or is not complete, this milestone allows IME to send the ISIS flow back to the service worker or case manager with instructions to complete the assessment.
13 SW/CM	If applicable, responds to ISIS milestone "Assessment not received" by correcting any problem in delivering the assessment to IME and clicking "OK" on the milestone screen.
14 SW/CM	If received, responds to ISIS milestone "More information needed on assessment" by providing the required information and coordinating with IME as necessary.
15 IME MS Reviewer	If applicable, responds again to the ISIS milestone "Determine assessment status." This milestone and the service worker or case manager milestones must be repeated until the assessment is received and is complete.
16 IME MS Reviewer	Responds to ISIS milestone "Select LOC, enter effective date and CSR date." Note that selection of "Denied" from the pull-down menu means that a valid level of care has not been approved for this member.
17 IM	If received, responds to ISIS milestone "LOC has been denied, send NOD, if applicable." Makes entries on ABC to deny the waiver application.

Stage / Actor	Description
18 SW/CM	If received, responds to ISIS milestone "LOC has been denied, send NOD, check for other services." NOTE: If level of care is denied, the process ends here. The next steps in this process assume that a valid level of care has been approved.
19 SW/CM	If respond to ISIS milestone "LOC approved, send NOD."
20 SW/CM	Watches for completion of level of care milestone by IME. Responds to the ISIS milestone "Complete service plan entries" by completing the plan and adjusting dates as necessary to ensure services don't start before the level of care effective date. Do NOT respond positively to this milestone until you have actually entered the service plan into ISIS (using the ISIS SERVICE PLAN screen and associated WORKSHEET screens). NOTE: Approval of the service plan is for the entire plan as defined, and not just for selected services.
21 SW/CM	Convenes the interdisciplinary team to determine necessary and appropriate services for the consumer. Obtains a release of information from the consumer or legal representative to share information with providers. NOTE: A service plan may be developed while the level of care is being determined.
22 SW/CM	Develops the written service plan based on the interdisciplinary team meeting results, and enters the plan into ISIS as a proposed plan while waiting for level of care determination and level of care effective date. The ISIS service plan is created using the ISIS SERVICE PLAN screen and associated WAIVER SERVICES AGREEMENT WORKSHEET screen. (See 14-M for details on using these screens.)
23 SW/CM	Ensures that the consumer and the provider complete and sign form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, when CDAC services are authorized. Attaches a copy of the completed form 470-3372 to the paper copy of the service plan. Each provider that may provide the CDAC service must complete and sign a separate form 470-3372.

Stage / Actor	Description
24 MS PA Reviewer	Receives and responds to the ISIS milestone "Do you accept the service plan?" Chooses from three responses. Do you accept the service plan? Do units exceed maximum? Is this an increase from previous plan or new service?
25 SW/CM	**Approve:** If the changes to the service plan have been authorized by the MS PA Reviewer, make changes to the service plan. Send an NOD. **Negotiate:** If the MS PA Reviewer requests changes to the service plan, the MS PA may call CM and a case conference may be held. Are the changes to the service plan complete? If an agreement is reached, the CM may then make changes to the service plan and send an NOD. **Deny:** If the MS PA Reviewer has denied, send an NOD, and check for other services.
26 IM	If the MS PA Reviewer rejects the service plan, receives and responds to the ISIS milestone "MS PA Reviewer authorization has been denied. Send NOD if applicable." Makes ABC entries to deny the waiver application.
27 SW/CM	If the MS PA Reviewer rejects the service plan, receives and responds to the ISIS milestone "MS PA Reviewer authorization denied, send NOD, check for other services.
28 IM	Responds to ISIS milestone "Level of care has been set. Verify aid type is correct in ABC." Enters corrections into the ABC system as necessary.
29 IM	Responds to ISIS milestone "Approval of Medicaid eligibility & facility/waiver services." A positive response gives final authorization for the program requested. If the ID waiver application is approved, verifies that the earliest of all three key dates (level of care date, financial eligibility date, and service start date) is chosen as the date of Medicaid eligibility.

Stage / Actor	Description
30 IME	If the ID waiver application is **not** approved, receives and responds to the ISIS milestone "Medicaid eligibility &/or facility/waiver services have been denied." **or** If the ID waiver application **is** approved, receives and responds to the ISIS milestone "Medicaid eligibility & facility/waiver services have been approved. Send NOD, if applicable." The requirement to send a notice of decision will be a rare event.
31 SW/CM	If the ID waiver application is **not** approved, receives and responds to the ISIS milestone "Medicaid eligibility &/or facility/waiver services have been denied. Send NOD. Check for other services." Sends a notice of decision to the member, the member's legal representative, or both denying waiver services. For guidelines regarding information to be included, see Notice of Decision Completion. **or** If the ID waiver application **is** approved, receives and responds to the ISIS milestone "Medicaid eligibility & facility/waiver services have been approved. Send NOD, if applicable." Sends a notice of decision to the member, the member's legal representative, or both and the providers of services approving services. See Notice of Decision Completion for guidelines regarding information to be included.
32 SW/CM	If the ID waiver application is approved, reviews the need for waiver services annually or when there is a significant change in the person's situation or condition. NOTE: Upon waiver enrollment, all members must have a Medicaid case manager. A DHS service worker may also be involved if the member receives other state-funded services that require service coordination.
33 SW/CM	Completes a service plan at least annually (both written and in ISIS).

Service Plan Authorization and Rate Changes

Legal reference: 441 IAC 79.1(2)

Case managers are responsible to receive service plan authorization whenever there is an increase in the amount of services, an increase in a service rate, or when a new service is added to a member's service plan. Service plan authorization workflow has been developed in ISIS to request, review, and authorize changes to a service plan. The service plan authorization workflow is started when changes are made to the member's service plan. See ISIS Service Plan Entries in the Procedures Common to All Waivers section of this manual.

Service Plan Authorization

The IME is responsible for authorization of all service plans for adults on the BI and ID waivers. Please note the following points related to service plan authorization for adult members on the BI and ID waivers:

- All service plan changes (units, rates, services, dates, etc.) will require the case manager to certify whether there was an increase to service unit amounts, service cost (rates), and services identified.
- Any increase in service unit amounts, service costs or the addition of a new service will trigger a new milestone in the Individualized Services Information System (ISIS) that will require service plan approval by the IME.
- The IME Prior Authorization (PA) reviewers will gather member details from ISIS, review assessment documentation, and may phone the CM or TCM for more information if necessary.
- Case managers should be prepared to answer questions related to the medical necessity of service plan changes.
- Information related to the service plan is reviewed by the IME.
- The IME staff will provide final authorization for the plan when it is determined that it meets the medical needs of the member.
- Waiver Prior Authorization (WPA) workflow for adults on the BI and ID waiver has been replaced with service plan authorization.
- The CM is no longer required to submit the WPA Certificate of Medical Necessity unless requested by the IME. The CM should be prepared to answer any or all questions that are in the Certificate of Medical Necessity.

As part of the service plan authorization, the IME will review and approve daily SCL rates (W1401). A case manager may enter three types of daily rates into a member's service plan based on the rate methodology used by the provider:

- Finalized cost report rates,
- Projected site rates using Schedule D-4, or
- Individual rates using a Schedule D-4.

Finalized Cost Report Rates

A provider is required to annually submit a cost report including all SCL daily site rates (W1401) with the IME Provider Cost Audit (PCA) unit. The cost report process requires a provider to submit financial information to support the costs associated with each site where SCL services are provided.

Upon review and finalization of the cost report, the IME PCA unit will issue a letter to the provider that identifies the approved cost report rate for each site and the effective date for the rate.

If a provider chooses to use the finalized cost report site rate, a case manager will enter the rate into the member's service plan and follow the ISIS workflow for approval.

If finalized cost report site rates are used, there is no contact with an IME Medical Services reviewer. The service plan will be approved without further review. The case manager will send out a notice of decision approving the cost report rate.

The case manager will be required to have the supporting documentation from the provider to support the finalized cost report site rate in the member's service plan file.

The finalized cost report site rate will remain in effect for the SCL site until:

- The provider requests a different rate based on changing needs of the member's living in the home, or
- A new finalized cost report site rate is established through the year end cost report process.

If one or more members move out of the home during the year, the provider may choose to continue using the finalized cost report site rate for any new members moving into the home. If there is a need to establish a new site rate based on the changing needs of a member within the site, the provider must establish a new projected site rate through the IME PCA unit. Submit a site D-4 worksheet and individual D-4 worksheets for each member in the site as identified above.

Projected Site Rates

When a provider establishes a new daily SCL site or requests a rate change for an existing daily SCL site, they must establish a new projected site rate with IME PCA.

The provider must submit a site D-4 worksheet and individual D-4 worksheet for each member in the site to IME PCA for review and approval.

Once received, the IME PCA unit, in conjunction with the IME Medical Services reviewer, will review the site D-4 worksheet, individual D-4 worksheets, and service plan to determine medical necessity and establish a new projected site rate.

The IME PCA will send the provider both the approved individual D-4 rates for all members in the home and the new approved projected site rate.

The provider may choose to use either of the rates, but must use either the individual rates **or** the projected site rate. A provider may not use a combination of the individual and site rates within the site.

The case manager will be required to have the supporting documentation from the provider to support the projected site rate in the member's service plan file.

If a provider chooses to use the approved projected site rate, a case manager will enter the rate into the member's service plan and follow the ISIS workflow for approval. If projected site rates are used, there is no contact with an IME Medical Services PA reviewer. The service plan will be approved without further review.

Projected site rates will remain in effect for the SCL site until:

- The provider requests a different rate based on changing needs of the member's living in the home, or
- A new cost report rate is established through the year end cost report.

If one or more members move out of the home during the year, the provider may choose to continue to use the projected site rate for any new members moving into the home. If there is a need to establish a new site rate based on the changing needs of a member within the site, the provider must establish a new projected site rate through the IME PCA unit. Submit a site D-4 worksheet and individual D-4 worksheet for each member in the site as identified above.

Individual D-4 Site Rates

If a provider chooses to use the approved individual D-4 rate, the case manager will enter the rate into the member's service plan and follow the ISIS workflow for approval. If the individual member's rate increase is based on a change in the member's need, the ISIS workflow will prompt the case manager to have supporting information available on the need for the change. The IME Medical Services PA Reviewer may be in contact to determine the need for the change is service.

If the increase in an individual rate is not based on a change in need of the member and is caused by a change in need of a roommate, the ISIS workflow will prompt the case manager to approve the plan. The service plan will be approved without further review by the IME. The case manager will be required to have the supporting documentation from the provider to support the individual rate in the member's service plan file.

Individual D-4 rates will remain in effect until there is a service needs change for **any** member living in the home that requires a new rate to be established.

When a change is needed, the provider must submit the site D-4 worksheet and individual D-4 worksheets to the IME PCA unit for all individuals living within the home and the site daily rate worksheet to establish new individual rates. The provider must send the new individual D-4 rates to all case managers to enter the new rate into the member's service plan. The case manager will follow the ISIS workflow to approve the new rates.

A provider may change the rate methodology used at any time by submitting the new rate and supporting documentation to the case manager for entry into the member's service plan.

SCL Daily Rate Plan Approval Process for Case Managers

Event	Actions/Response
Receives daily site rate from provider	CM enters the new rate into service plan and follows ISIS prompts. CM must determine the rate type used by the provider and respond accordingly in ISIS. The provider will submit information to the case manager to support the rate change request. The following actions are taken by the CM based on the event.
Receive a decrease in the daily site rate	Enter the rate into ISIS and follow the milestone prompt to approve the plan. No IME Medical Services PA review is required. Send NOD to provider.
Receive a new finalized cost report site rate	Providers are required to submit year end cost reports to IME PCA unit annually. A provider receives a new finalized cost report site rate from IME PCA based on the year end cost report. The provider will submit a copy of the finalized cost report site rate sheet sent to them by IME PCA for the site in which the member resides. Enter the finalized cost report site rate into ISIS and follow the milestone prompt to approve the plan. No IME Medical Services PA review is required. Send NOD to provider.
Receives an existing finalized cost report site rate	This rate is used when one member moves out of a site and a new member moves into a site that is using a finalized cost report site rate. The provider may choose to use the existing finalized cost report rate for the member moving into the site. The provider will submit a copy of the finalized cost report site rate sheet sent to them by IME PCA for the site in which the member resides. Enter the existing finalized cost report site rate into ISIS and follow the milestone prompt to approve the plan. No IME Medical Services PA review is required. Send NOD to provider.

Event	Actions/Response
Receives new projected site rate	This rate is used when a brand new site is developed by the provider or when a provider develops a new projected site rate due to changing needs of members living in the site. Enter the projected rate into ISIS and follow the milestone prompt to approve the plan. No further IME Medical Services PA review is required. Send NOD to provider. NOTE: Individual D-4 worksheets will have been previously reviewed and approved by the CM before receiving the request to use a new projected site rate.
Receives existing projected site rate	This rate is used when one member moves out of a site and a new member moves into a site that is using a projected site rate. The provider may choose to use the existing projected site rate for the member moving into the site. The provider will submit a copy of the projected rate sheet sent to them by IME PCA for the site. Enter rate into ISIS and follow the milestone prompt to approve the plan. No IME Medical Services PA review is required. Send NOD to provider.
Receives individual D-4 rate from the provider	This rate is used when a provider chooses to use the individual D-4 rate for the member. Provider will submit a copy of the individual D-4 schedule approved by the IME PCA for the member. Enter rate into ISIS and follow the milestone prompt to approve the plan. No IME Medical Services PA review is required. Send NOD to provider.

Event	Actions/Response
Receives an individual D-4 worksheet from provider	Reviews pages 2 & 3 of the submitted individual D-4 worksheet and signs off when the service needs of the member are identified in the projected rate developed by the provider. The individual D-4 worksheet will be received when: ♦ A new site is being developed. ♦ A new site rate is being developed based on a change in need of a member living within the site. NOTE: A CM will only receive and review a D-4 schedule of the member with the service needs change. If the site rate is changing due to the needs of others in the home, the CM will only receive the new projected rate from the provider with a note stating the rate change is due to the change in needs of others in the site.
Signs the individual D-4 worksheet	Sends signed individual D-4 worksheet back to provider. Keeps documentation to support the individual D-4. May receive a phone call from the IME Medical Services PA Reviewer with questions about the service needs of the member.
Receives call from IME Med Services PA Reviewer	Be prepared to communicate the member's needs to Med Services PA reviewer. The CM should have enough information to support the need for the amount of service in the plan to support the requested rate.

Services Available Under the ID Waiver

Legal reference: 77.37(249A), 78.41(249A), 79.1(2), 79.1(15)

ID waiver services are individualized to meet the needs of each member. The following services are available:

- Adult day care
- Consumer choices option
- Consumer-directed attendant care (CDAC)
- Day habilitation
- Home and vehicle modification (HVM)
- Home health aide (HHA)
- Interim medical monitoring and treatment (IMMT)
- Nursing
- Personal emergency response system (PERS)
- Prevocational services
- Residential-based supported community living
- Respite
- Supported community living (SCL)
- Supported employment (SE)
- Transportation

Physical Disability Waiver

Legal reference: 441 IAC 77.41(249A), 78.46(249A), Chapter 83, Division VI

The Medicaid home- and community-based services physical disability waiver (HCBS PD) provides service funding and individualized supports to maintain eligible people in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective.

The services that are considered necessary and appropriate for the member will be determined through an interdisciplinary team consisting of the member, DHS service worker, service providers, and other people the member chooses.

Funding must be available either through the state of Iowa based on individual level of care determination. Assistance may be available through the in-home health-related care program and the rent subsidy program in addition to services available through the PD waiver. Members interested in applying for rent subsidy should contact the following address:

Iowa Finance Authority
HCBS Rent Subsidy Program
2015 Grand Ave.
Des Moines, IA 50312

The following sections explain:

- Waiver eligibility criteria
- The member enrollment process
- The services available under the waiver

PD Waiver Eligibility Criteria

Legal reference: 441 IAC 83.102(249A), 83.103(3)

A person may be eligible for HCBS PD waiver services if the person meets all of the following criteria:

- The person has a physical disability.
- The person is blind or disabled as determined by the receipt of Social Security Disability benefits or by a disability determination made through the Bureau of Long-Term Care.

- The person is between the ages of 18 through 64 years.
- The person is eligible for Medicaid under:
  - An SSI-related or FMAP-related coverage group or
  - The special income level of 300 percent of the maximum monthly Supplemental Security Income coverage group, consistent with a level of care in a medical institution.

  Consumers may be Medicaid members before requesting waiver services or may be determined eligible through the application process for the waiver program. Additional opportunities to access Medicaid may be available through the waiver program even if the consumer has previously been determined ineligible.
- The person is determined by the Iowa Medicaid Enterprise (IME) Medical Services Unit to need one of the following levels of care:
  - Intermediate care facility (ICF)
  - Skilled nursing facility (SNF)
- The person is ineligible for the HCBS ID waiver.
- The person has the ability to hire, supervise, and fire the HCBS PD service provider as determined by the DHS service worker. The person must be willing to do so or have a guardian named by probate court who will assume this responsibility on the person's behalf.

Conditions of PD Eligibility

Legal reference: 441 IAC 83.102(2)"b," 83.103(2)

The applicant must choose HCBS as an alternative to institutional services.

As a precondition of eligibility for the PD waiver, applicants shall access all other services for which they are eligible and which are appropriate to meet their needs. Following is the hierarchy for accessing waiver services:

- Private insurance
- Medicaid, including EPSDT (Care for Kids)
- Physical disability waiver services
- In-home health-related care. (NOTE: This relationship is discussed further under consumer-directed attendant care. See Relationship to Other Services.)

Eligibility shall be effective as of the date when both the waiver eligibility criteria and the need for services have been established. HCBS PD waiver services provided before both approvals of eligibility for the waiver cannot be paid.

The member must need and use, at a minimum, one unit of CDAC or personal emergency response system service during each quarter of the calendar year.

The cost of services shall not exceed $659 per month. Home and vehicle modifications and specialized medical equipment costs shall not exceed $500 per month or $6,060 per year, and be part of the total of $659 for all PD waiver services.

Agencies shall submit service costs. Review the service unit needs identified in the service plan and assessment to ensure that they are within service limits. Review individualized service costs to ensure that reimbursement is within unit maximums.

In order to receive PD waiver services, an approved PD waiver service provider must be available to provide those services. Medicaid waiver service cannot be simultaneously reimbursed with another Medicaid waiver service or a Medicaid service. PD waiver services cannot be provided when a person is an inpatient of a medical institution.

PD Service Plan

Legal reference: 441 IAC 83.102(2), 83.107(249A)

All members will have a service plan developed by a DHS service worker in cooperation with the member. Refer to Service Plans for federal requirements for HCBS service plans.

In addition to the federal service plan requirements, following are service plan requirements for the HCBS PD program. A service plan must be:

- Developed at the onset of services. This plan must be completed before services are implemented. Develop a service plan within 30 calendar days of acceptance for service (the date when all eligibility criteria have been met), based on the information currently available.

- Developed annually in cooperation with the member. Work together as a team with the member to develop the service plan. With the member, determine the services and the amount of services to be received.
- Approved by the member and the DHS service worker. Submit the service plan in permanent written form and have it dated and signed by the member or the member's guardian.
- Reviewed on an annual basis thereafter or as necessary if service needs change. At a minimum, review the service plan annually, as required under Redetermining Eligibility.

Develop or review service plans for member s aged 20 or under after the individual education plan (IEP) and early and periodic screening, diagnosis and treatment (EPSDT) plan (if applicable) are developed, so as not to replace or duplicate services covered by those plans.

Other people may be included on the service planning team. With the member's approval, the team may include:

- The member's legally authorized representative.
- The member's family, unless the family's participation is limited by court order or is contrary to the wishes of an adult member who has not been legally determined to be unable to make decisions.
- All current service providers.
- People whose appropriateness is identified through the initial intake or current review.
- People identified by the family, provided the wishes of the family are not in conflict with the desires of the member.

Plan Content

Legal reference: 441 IAC 83.107(1)

Prepare service plans for PD waiver clients using form 470-0583, *Individual Client Case Plan*. (See 16-K-Appendix for instructions.)

The service plan needs to include all services the member needs and is to receive. The plan shall contain the following:

- Individualized member goals, which are general statements of expected accomplishments to be achieved in meeting the needs identified in the initial intake or current review. Base these goals on the member's strengths, needs, and abilities.
- Objectives, which may be prioritized and which are specific, measurable, and time-limited statements of outcome or accomplishments that are necessary for progress toward each goal.
- The specific service activities to be provided to achieve the objectives, based on appropriateness, availability, and accessibility of the services and financial resources.
- The people or agencies responsible for providing each service activity.
- The date of initiation, specific amounts, and anticipated duration of each service activity.
- The living arrangements and service settings selected to meet the member's needs, the rationale for this determination, and the rationale for any variation from use of least restrictive interventions.
- The people legally authorized to act on behalf of the member, when applicable.
- Additional services, resources, and supports that are needed but unavailable.
- Recommendations for guardianship or conservatorship.
- Identification of a crisis intervention plan for the member.
- Identification of any limitations on the member's rights.
- Documentation and justification of any limits on the member's ability to manage funds and any objections to the service plan.

The service plan shall document:

- The service need
- The number of service units to be received
- The start date and recertification date
- The funding source
- The service provider

When CDAC is authorized, the services shall be provided as specifically delineated in form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*. A copy of this form must be given to the service worker or case manager before the service can begin. Attach a copy of the completed agreement form to the service plan. If the member has a guardian, the service plan shall address how CDAC services will be monitored to ensure the member's needs are adequately met.

Choice of Program

Legal reference: 441 IAC 83.102(1)"i," 83.103(2)"d"

The discharge planner, the IM worker, or the service worker should explain to the member the choice between waiver services and institutional care.

The member or the member's parent, guardian, or attorney under a durable power of attorney for health care shall complete and sign form 470-5044, *Service Worker Comprehensive Assessment*, indicating the member's choice of institutional or HCBS waiver services.

PD Member Enrollment Process

Legal reference: 441 IAC 83.103(249A)

The following sequence describes the process for enrolling a member in the physical disability (PD) waiver program, including the actions of:

- The income maintenance worker (IM)
- The facility discharge planner (DP)
- The service worker or case manager (SW/CM)
- The case manager supervisor (CM SUP)
- The Iowa Medicaid Enterprise Medical Services Unit (IME)

Stage / Actor	Description
1 IM	Receives request for application for HCBS Physical Disability services. Enters the case into the ABC system.
2 IM	The member has been given the choice between HCBS waiver services and institutional services. Do you want to continue with waiver eligibility? The IM worker would normally respond by clicking the CONTINUE button on this milestone screen, unless certain that the member will not qualify financially or for some other obvious reason. If the IM worker's response is negative, the process will not continue in ISIS, and the IM worker must deny the case in ABC. This allows a case to be denied before it is sent on to any other agency (such as IME). If the choice is for facility care, the IM worker denies the request for waiver eligibility in ABC. If the choice is for home- and community-based services, IM will document this in the case file.
3 IM	Responds to the ISIS milestone "What is the result of the disability determination?" NOTE: A disability determination is needed when the applicant's Medicaid eligibility is based on a disability. The disability determination is not needed when the Medicaid eligibility is based solely upon another coverage group that is not dependent on disability. Recommend pursuing a disability determination whenever there is a possible disability, but continue to process the application based on the other coverage group. If the response is "not disabled," the process ends here. No further milestones will be generated in ISIS. The IM worker makes entries in ABC to deny the waiver application. If the response is "disabled" or "not applicable," the process continues.

Stage / Actor	Description
4 Slot Manager	Responds to the ISIS milestone "Is a slot available?" If a slot is available, the case is referred to the service or case management supervisor who was assigned via the ROLES screen. If a slot is not available, the slot manager places the member on a waiting list.
5 IM	For the initial application the IM worker gives form 470-4392, *Level of Care Certification for HCBS Waiver Program*, to the applicant to take to their physician.
6 IM	If the slot is not available, responds to milestone "Slot is not available. Make entries in ABC." The IM Worker should deny the member's application in ABC at this point. ISIS will generate no further milestones.
7 SW/CM	Meets with member to determine if there are any immediate needs that need to be addressed and refer to the appropriate resource. Coordinate completion of assessment and confirm assessment has been sent to Medical Services.
8 SW/CM	Responds to ISIS milestone Complete assessment.
9 IM	If withdrawn deny application in ABC.
10 Slot Manager	Will update the slot database.
11 IME	Responds to ISIS milestone "Determine assessment status." Allow reasonable time for the assessment to reach IME. If the assessment is not received or is not complete, this milestone allows the IME Medical Services Unit to send the ISIS flow back to the service worker or case manager with instructions to complete the assessment.
12 SW/CM	If applicable, responds to ISIS milestone "Assessment not received" by correcting any problem in delivering the assessment to IME and clicking "OK" on the milestone screen.
13 SW/CM	If received, responds to ISIS milestone "More information needed on assessment" by providing the require information and coordinating with the Medical Services Unit as necessary.

Stage / Actor	Description
14 IME	If applicable, responds again to the ISIS milestone "Determine assessment status." This milestone and the service worker or case manager milestone must be repeated until the assessment is received and is complete.
15 IME	Responds to ISIS milestone "Select LOC, enter effective date and CSR date." Note that selection of "Denied" from the pull-down menu means that a valid level of care is not approved for this member.
16 IM	If received, responds to ISIS milestone "LOC has been denied, send NOD." Makes entries on ABC to deny the waiver application.
17 SM	If the level of care is denied the slot manager will update the database.
18 SW/CM	If received, respond to ISIS milestone "LOC has been denied, send NOD, check for other services." NOTE: If level of care is denied, the process ends here. The next steps in this process assume that a valid level of care has been approved.
19 IM	If the level of care selection is a change to the person's established level of care, receives and responds to ISIS milestone "Level of care has been set. Verify aid type is correct in ABC." Enters corrections into the ABC system as necessary.
20 SW/CM	Watches for completion of level of care milestone by the Medical Services Unit (whether a new level of care or a change to level of care). Responds to the ISIS milestone "Complete service plan entries" by completing the plan and adjusting dates as necessary to ensure that services don't start before the level of care effective date. Do NOT respond positively to this milestone until you have actually entered the service plan into ISIS (using the ISIS SERVICE PLAN screen and associated WORKSHEET screens). NOTE: Approval of the service plan is for the entire plan as defined, and not just for selected services.

Stage / Actor	Description
21 SW/CM	Convenes the interdisciplinary team to determine necessary and appropriate services for the member. Obtains a release of information from the member or legal representative to share information with providers. Consumer choices options needs to be offered as a service choice. NOTE: A service plan may be developed while waiting on the level of care is being determined.
22 SW/CM	Develops the written service plan based on the interdisciplinary team meeting results, and enters the plan into ISIS as a proposed plan while waiting for level of care (LOC) determination and a level of care effective date. The ISIS service plan is created using the ISIS SERVICE PLAN screen and associated WAIVER SERVICES AGREEMENT WORKSHEET screen. (See 14-M for details on using these screens.)
23 SW/CM	Assures that the member and provider complete, sign, and date form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, when CDAC services are authorized. Each provider that may provide the CDAC service must complete, sign, and date a separate agreement. A copy of each completed form 470-3372 must be attached to and become part of the paper copy of the service plan. Assures that the member is made aware of the Consumer Choices Option available under the Elderly waiver and assists in this process if the member chooses this option.
24 IM	Responds to ISIS milestone "Approval of Medicaid eligibility & facility/waiver services." A positive response gives final authorization for the program requested. If the Physical Disability waiver application is approved, verifies that the earliest of all three key dates (level of care date, financial eligibility date, and service start date) is chosen as the date of Medicaid eligibility.

Stage / Actor	Description
25 IME	If the Physical Disability waiver application is not approved, receives and responds to the ISIS milestone "Medicaid eligibility &/or facility/waiver services have been denied." **or** If the Physical Disability waiver application is approved, receives and responds to the ISIS milestone "Medicaid eligibility & facility/waiver services have been approved. Send NOD, if applicable." The requirement to send a notice of decision will be a rare event.
26 SW/CM	If the physical disability waiver application is not approved, ♦ Receives and responds to the ISIS milestone "Medicaid eligibility &/or facility/waiver services have been denied. Send NOD. Check for other services." ♦ Sends form 470-0602, *Notice of Decision: Services*, to the applicant and the applicant's legal representative, if applicable, denying waiver services. **or** If the physical disability waiver application is approved, ♦ Receives and responds to the ISIS milestone "Medicaid eligibility & facility/waiver services have been approved. Send NOD, if applicable." ♦ Sends form 470-0602, Notice of Decision: Services, to the member and the member's legal representative, if applicable, and the providers of services approving services. See Notice of Decision Completion for guidelines regarding information to be included on form 470-0602.
27 SW/CM	If the physical disability waiver application is approved, reviews the need for waiver services annually or when there is a significant change in the person's situation or condition.
28 SW/CM	Completes a service plan and level of care at least annually (both written and in ISIS).

Services Available Under the PD Waiver

Legal reference: 441 IAC 77.41(249A), 78.46(249A)

PD waiver services are designed to be flexible to meet the needs of each member. The following services are through the PD waiver available:

- Consumer choices option
- Consumer-directed attendant care (CDAC)
- Home and vehicle modification (HVM)
- Personal emergency response (PERS)
- Specialized medical equipment
- Transportation

Individualize all services to the member. Include necessary instruction, supervision, assistance, and support, as required to assist the member in achieving life goals. Provide services in the least restrictive environment. The following sections describe the requirements for each service.

Waiver Service Descriptions

Adult Day Care

Legal reference: 481 IAC Chapter 70
AIDS: 441 IAC 77.34(7), 78.38(7)
BI: 441 IAC 77.39(20), 78.43(9)
Elderly: 441 IAC 77.33(1), 78.37(1)
HD: 441 IAC 77.30(3), 78.34(3)
ID: 441 IAC 77.37(25), 78.41(12)

Adult day care services provide an organized program of supportive care in a group environment to people who need a degree of supervision and assistance on a regular or intermittent basis in a day care center.

Components of this service may include:

- Medical emergency services
- Rehabilitative services
- Personal care services
- Nutrition services
- Social work services
- Patient activities services
- Transportation services

Adult day care providers shall be agencies that are certified by the Department of Inspections and Appeals as being in compliance with its standards for adult day services programs.

A unit of service is either:

- An extended day (8 to 12 hours),
- A full day (4 to 8 hours), or
- A half-day (1 to 4 hours).

For the **ID** waiver, the cost of transportation to and from the day care site must be included in the provider's rate.

Assisted Living On-Call Service

Legal reference: Elderly: 441 IAC 77.33(23), 78.37(18), 79.1(2)

The assisted living on-call service provides staff on call 24 hours per day to meet a member's scheduled, unscheduled, and unpredictable needs in a manner that promotes maximum dignity and independence and provides safety and security.

A unit of service is one day. To determine units of service provided, the provider will use census information based on member bed status each day.

Assisted living on-call service providers shall be assisted living programs that are certified by the Department of Inspections and Appeals under 481 IAC Chapter 69.

Assistive Devices

Legal reference: Elderly: 441 IAC 77.33(13), 78.37(13), 79.1(2)

Assistive devices means practical equipment to assist people with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to:

- Long-reach brush
- Extra-long shoe horn
- Nonslip grippers to pick up and reach items
- Dressing aids
- Transfer boards
- Shampoo rinse tray and inflatable shampoo tray
- Double-handled cup and sipper lid

A unit is an item.

The following providers may provide assistive devices:

- Medicaid-eligible medical equipment and supply dealers
- Area agencies on aging
- Assistive devices providers with a contract with an area agency on aging or with a letter of approval from an area agency on aging stating the organization is qualified to provide assistive devices

- Community businesses that are engaged in the provision of assistive devices and that:
  - Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and
  - Submit verification of current liability and workers' compensation coverage.

Behavioral Programming

Legal reference: **BI:** 441 IAC 77.39(23), 78.43(12), 79.1(2)

Behavioral programming consists of individually designed strategies to increase the member's appropriate behaviors and decrease the member's maladaptive behaviors that have interfered with the member's ability to remain in the community.

Behavioral programming includes:

- A complete assessment of both appropriate and maladaptive behaviors.
- Development of a structured behavioral plan, which should be identified in the member's individual treatment plan.
- Implementation of the behavioral intervention plan.
- Ongoing training and supervision to caregivers and behavioral aides.
- Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to:

- Clinical redirection
- Token economies
- Reinforcement
- Extinction
- Modeling
- Over-learning

A unit of service is 15 minutes.

Providers must have experience with or training regarding the special needs of people with a brain injury. A psychologist or psychiatrist must do a formal assessment of the member's intellectual and behavioral functioning. A qualified brain injury professional must:

- Assess behavior.
- Develop and reassess the intervention plan.
- Train staff to implement the plan.

Behavioral aides who implement the plan and train and supervise caregivers must be employed by:

- A community mental health center,
- A hospice,
- A mental health service provider,
- A home health aide provider (under the elderly waiver or Medicare), or
- A brain injury waiver provider.

Case Management

Legal reference: **BI:** 441 IAC 77.39(12), 78.43(1), 79.1(2)
Elderly: 441 IAC 77.33(21), 78.37(17), 79.1(2)

Members who are eligible for Medicaid targeted case management are not eligible for case management as a waiver service.

Members who are eligible for targeted case management receive that service in addition to waiver services, not as part of the waiver.

Payment for waiver case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the member during a month when the member is enrolled.

Brain Injury Waiver Case Management

For the brain injury waiver, "individual case management services" means activities provided, using an interdisciplinary process, to people with a brain injury to:

- Ensure that the person has received a evaluation and diagnosis,
- Give assistance to the person in obtaining appropriate services and living arrangements,
- Coordinate the delivery of services, and
- Provide monitoring to ensure the continued appropriate provision of services and the appropriateness of the selected living arrangement.

BI case management services shall consist of the following components:

- Intake, which includes ensuring that there is sufficient information to identify all areas of need for services and appropriate living arrangements.
- Assurance that a service plan is developed which addresses the member's total needs for services and living arrangements.
- Assistance to the member in obtaining the services and living arrangements identified in the service plan.
- Coordination and facilitation of decision making among providers to ensure consistency in the implementation of the service plan.
- Monitoring of the services and living arrangements to ensure their continued appropriateness for the member.
- Crisis assistance to facilitate referral to the appropriate providers to resolve the crisis. The intent and purpose of the individual case services are to facilitate the member's access to the service system and to enable members and their families to make decisions on their own behalf by providing:
  - Information necessary for decision making.
  - Assistance with decision making and participation in the decision-making process affecting the member.
  - Assistance in problem solving.
  - Assistance in exercising the member's rights.

The service is to be delivered so as to enhance the capabilities of members and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the member to:

- Exercise choice,
- Make decisions,
- Take risks which are a typical part of life, and
- Fully participate as a member of the community.

It is essential that the case manager develop a relationship with the member so that the abilities, needs and desires of the member can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual members.

Case management provider organizations are eligible to participate in the BI waiver if they meet the accreditation standards in 441 Iowa Administrative Code Chapter 24. The organization may be:

- The Department of Human Services,
- A county or consortium of counties, or
- A provider under subcontract to the Department or to a county or consortium of counties.

Elderly Waiver Case Management

Under the elderly waiver, case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

Case management is provided at the direction of the member and the interdisciplinary team according to the same standards as set for Medicaid targeted case management in relation to service provision and provider requirements. Covered services include:

- Assessment and reassessment of the member's individual needs,
- Development and review of the member's service plan,
- Service referral and related activities,
- Monitoring and follow-up to ensure:
  - The health, safety and welfare of the member, and
  - Effective implementation of a service plan that adequately addresses the needs of the member.
- A face-to-face contact with the member every three months and at least one contact per month with the member or the member's representative, family, service providers, or other entities or individuals involved in the member's case.

An agency or individual is eligible to participate in the elderly waiver program as a case management provider if the agency or individual meets one of the following standards:

- Is accredited by the mental health, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441 IAC Chapter 24; or
- Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or
- Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or
- Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or
- Is approved by the Department on Aging as meeting its standards for case management services in 17 IAC Chapter 21; or
- Is authorized to provide similar services through a contract with the Iowa Department of Public Health (IDPH) for local public health services. meets the qualifications for case managers in 641 IAC subrule 80.6(1); and provides a current IDPH local public health services contract number.

A case management provider shall not provide direct services to the consumer. The Department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest.

A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:

- Specific procedures to identify conflicts of interest.
- Procedures to eliminate any conflict of interest that is identified.
- Procedures for handling complaints of conflict of interest, including written documentation.

Chore Service

Legal reference: Elderly: 441 IAC 77.33(7), 78.37(7), 79.1(2)

Chore services include the following services:

- Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows.
- Minor repairs to walls, floors, stairs, railings, and handles.
- Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting, and trash removal.
- Yard work, such as mowing lawns, raking leaves, and shoveling walks.

A unit of service is one-half hour.

The following providers may provide chore services:

- Home health agencies certified under Medicare.
- Community action agencies.
- Agencies authorized to provide similar services through a contract with the Department of Public Health. The agency must provide a current local public health services contract number.
- Nursing facilities.
- Providers that were enrolled as chore providers as of June 30, 3010, base on a subcontract with or letter of approval from an area agency on aging.
- Community businesses that are engaged in the provision of chore services and that:
  - Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and
  - Submit verification of current liability and workers' compensation coverage.

Consumer Choices Option Services

Legal reference:
AIDS: 441 IAC 78.38(9)
BI: 441 IAC 78.43(15)
Elderly: 441 IAC 78.37(16)
HD: 441 IAC 78.34(13)
ID: 441 IAC 78.41(15)
PD: 441 IAC 77.46(6)

The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. See Payment Under the Consumer Choices Option for information on how the individual budget is determined and managed.

Within the individual budget amount, the member shall have the authority to purchase goods and services and may choose to employ providers of service and supports. Components of this service are set forth below.

- **Required service components**: To participate in the consumer choices option, a member must:
  - Hire an independent support broker, and
  - Work with a financial management service that is enrolled as a Medicaid HCBS intellectual disability waiver service provider.
- **Optional service components**: A member who elects the consumer choices option may purchase the following services and supports, which shall be provided in the member's home or at an integrated community setting:
  - Self-directed personal care services.
  - Self-directed community supports and employment.
  - Individual-directed goods and services.

A case manager or service worker is assigned to each person as a resource to the member and the independent support broker. The case manager or service worker meets regularly with provider agencies to address complaints from members and families. Service provider agencies are required to report all incidents that could jeopardize the member's well-being.

The Iowa Medicaid Enterprise oversees quality issues statewide.

Financial Management Service

Legal reference: **AIDS:** 441 IAC 77.34(9), 78.38(9)"l"
BI: 441 IAC 77.39(26), 78.43(15)"l"
Elderly: 441 IAC 77.33(16), 78.37(16)"l"
HD: 441 IAC 77.30(13), 78.34(13)"l"
ID: 441 IAC 77.37(28), 78.41(15)"l"
PD: 441 IAC 77.41(7), 78.46(6)"l"

Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

- The financial institution shall either:
  - Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the Credit Union Division of the Iowa Department of Commerce; or
  - Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).
- The financial institution shall complete a financial management readiness review and certification conducted by the Department or its designee.
- The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.
- The financial institution shall enroll as a Medicaid provider.

Before initiation of a consumer choices option service, the member and the employee must enter into form 470-4428, *Financial Management Service Agreement*, with the designated financial institution.

The financial management service shall perform all of the following services.

- Receive Medicaid funds in an electronic transfer.
- Process and pay invoices for approved goods and services included in the individual budget.
- Enter the individual budget into the Web-based tracking system chosen by the Department and enter expenditures as they are paid.

- Provide real-time individual budget account balances for the member, the independent support broker, and the Department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- Conduct criminal background checks on potential employees pursuant to 441 Iowa Administrative Code Chapter 119.
- Verify for the member an employee's citizenship or alien status.
- Assist the member with fiscal and payroll-related responsibilities, including but not limited to:
  - Verifying that hourly wages comply with federal and state labor rules.
  - Collecting and processing timecards.
  - Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  - Computing and processing other withholdings, as applicable.
  - Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  - Preparing and issuing employee payroll checks.
  - Preparing and disbursing IRS Forms W-2 and W-3 annually.
  - Processing federal advance earned income tax credit for eligible employees.
  - Refunding over-collected FICA, when appropriate.
  - Refunding over-collected FUTA, when appropriate.
- Assist the member in completing required federal, state, and local tax and insurance forms.
- Establish and manage documents and files for the member and the member's employees.
- Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget.
- Keep records of all timecards and invoices for each member for a total of five years.

- Provide to the Department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- Establish a customer services complaint reporting system.
- Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- Develop a business continuity plan in the case of emergencies and natural disasters.
- Provide to the Department an annual independent audit of the financial management service.
- Assist in implementing the state's quality management strategy related to the financial management service.

The financial management service receives a standard fee of $64.01 per month for each member enrolled in the consumer choices option.

Independent Support Broker

Legal reference:
AIDS: 441 IAC 77.34(10), 78.38(9)"k"
BI: 441 IAC 77.39(27), 78.43(15)"k"
Elderly: 441 IAC 77.33(17), 78.37(16)"k"
HD: 441 IAC 77.30(14), 78.34(13)"k"
ID: 441 IAC 77.37(29), 78.41(15)"k"
PD: 441 IAC 77.41(8), 78.46(6)"k"

To participate in the consumer choices option, a member must select an independent support broker who meets the following qualifications:

- The broker must be at least 18 years of age.
- The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.
- The broker shall not provide any other paid service to the member.
- The broker shall not work for an individual or entity that is providing services to the member.

- The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
- The broker must complete an independent support brokerage certification approved by the Department.
- The member (and the member's personal representative, if any) and the independent support broker must complete form 470-4492, *Consumer Choices Option Independent Support Broker Agreement*, to formalize the terms of the relationship.

The independent support broker shall perform the following services as directed by the member or the member's representative:

- Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- Complete the required employment packet with the financial management service.
- Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- Assist the member with negotiating with entities providing services and supports if requested by the member.
- Assist the member with contracts and payment methods for services and supports if requested by the member.
- Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

- Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

The unit of service for the independent support broker is one hour. The payment rate may be negotiated between the member and the broker but shall not exceed $14.77 per hour.

The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget.

After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the Department.

Self-Directed Personal Care

Legal reference:
AIDS: 441 IAC 77.34(11), 78.38(9)"d"(1)
BI: 441 IAC 77.39(28), 78.43(15)"d"(1)
Elderly: 441 IAC 77.30(15), 78.37(16)"d"(1)
HD: 441 IAC 77.30(15), 78.34(13)"d"(1)
ID: 441 IAC 77.37(30), 78.41(15)"d"(1)
PD: 441 IAC 77.41(9), 78.46(6)"d"(1)

Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community.

The following are examples of services that a member may hire under self-directed personal care:

- Assistance with mobility transfers, dressing, personal grooming, and showering or bathing
- Companionship, supervision, and respite care
- Homemaking tasks, such as maintenance cleaning, laundry, meal preparation, and shopping
- Medication management
- Transportation

See Excluded Services for a list of items that may **not** be purchased as self-directed personal care services.

The member may purchase self-directed personal care services from:

- A business that has:
  - All the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
  - Current liability and workers' compensation coverage.
- An individual, including a friend or family member, who has all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

All personnel providing self-directed personal care services shall:

- Be at least 16 years of age; and
- Be able to communicate successfully with the member.

Rates and units of services are determined through negotiation between the member and the service provider as allowed within the individual budget. The provider of self-directed personal care services shall:

- Complete with the member form 470-4427, *Consumer Choices Option Employment Agreement.* This form specifies the responsibilities of the employee and the member. The form needs to be completed before the services begin and again if there are any changes.
- Complete with the member and the designated financial institution form 470-4428, *Financial Management Service Agreement*, to set up payment arrangements.
- Prepare form 470-4429, *Consumer Choices Option Semi-Monthly Time Sheet,* to identify what services were provided and the time when services were provided and have it approved by the member.
- Submit the approved form 470-4429 to the financial management service within 30 days from the date when the service was provided.

Self-Directed Community Supports and Employment

Legal reference:
AIDS: 441 IAC 77.34(13), 78.38(9)"d"(2)
BI: 441 IAC 77.39(30), 78.43(15)"d"(2)
Elderly: 441 IAC 77.33(20), 78.37(16)"d"(2)
HD: 441 IAC 77.30(17), 78.34(13)"d"(2)
ID: 441 IAC 77.37(32), 78.41(15)"d"(2)
PD: 441 IAC 77.41(11), 78.46(6)"d"(2)

Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration.

The following are examples of supports a member can purchase to help the member live and work in the community:

- Career counseling
- Career preparation skills development
- Cleaning skills development
- Cooking skills development
- Grooming skills development
- Job hunting and career placement
- Personal and home skills development
- Safety and emergency preparedness skills development
- Self-direction and self-advocacy skills development
- Social skills development training
- Supports to attend social activities
- Supports to maintain a job
- Time and money management
- Training on use of medical equipment
- Utilization of public transportation skills development
- Work place personal assistance

See Excluded Services for a list of items that may **not** be purchased as self-directed community supports and employment.

These supports are provided primarily a member's employee. Members may purchase self-directed community supports and employment from:

- A business providing community supports and employment that has:
  - All the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
  - Current liability and workers' compensation coverage.
- An individual, including a friend or family member, who has all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

All personnel providing self-directed community supports and employment shall:

- Be at least 16 years of age; and
- Be able to communicate successfully with the member.

Rates and units of services are determined through negotiation between the member and the service provider as allowed within the individual budget. The provider of self-directed community supports and employment shall:

- Complete with the member form 470-4427, *Consumer Choices Option Employment Agreement.* This form specifies the responsibilities of the employee and the member. The form needs to be completed before the services begin and again if there are any changes.
- Complete with the member and the designated financial institution form 470-4428, *Financial Management Service Agreement*, to set up payment arrangements.
- Prepare form 470-4429, *Consumer Choices Option Semi-Monthly Time Sheet,* to identify what services were provided and the time when services were provided and have it approved by the member.
- Submit the approved form 470-4429 to the financial management service within 30 days from the date when the service was provided.

Individual-Directed Goods and Services

Legal reference:
AIDS: 441 IAC 77.34(12), 78.38(9)"d"(3)
BI: 441 IAC 77.39(29), 78.43(15)"d"(3)
Elderly: 441 IAC 77.30(19), 78.37(16)"d"(3)
HD: 441 IAC 77.30(16), 78.34(13)"d"(3)
ID: 441 IAC 77.37(31), 78.41(15)"d"(3)
PD: 441 IAC 77.41(10), 78.46(6)"d"(3)

Covered individual directed goods and services are services, equipment or supplies that meet the following requirements:

- The item or service addresses an assessed need or goal identified in the member's service plan.
- The item or service is not otherwise provided through the Medicaid program and is not available through another source.
- The item or service is provided to the member or is directed exclusively toward the benefit of the member.
- The item or service can be accommodated within the member's budget without compromising the member's health and safety.
- The item or service increases the member's independence or substitutes for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
- The item or service promotes opportunities for community living and inclusion.
- The item or service is the least costly to meet the member's needs.

These items or services would primarily be purchased from a community business. The following are examples of services, equipment or supplies that a member may purchase under individual-directed services and supports:

- Appliances that promote or enhance independence such as shower chairs, dressing devices, special tooth brush, etc.
- Assistive devices such as a microwave oven or special utensils for meals
- Bus passes, taxi fare, or other transportation services
- Chore services or handyman services, including heavy cleaning, snow removal, and lawn care
- Cleaning services from firms or individuals

- Cooking services or delivery of prepared foods
- Employee advertising and background checks for potential employees
- Errand services to assist with banking, shopping or other types of routine tasks, or gas money to have a friend pick up groceries
- Home modifications such as ramps and grab bars and installation of visual or tactile alarms or wander alarms
- Laundry services from a laundromat or cleaners
- Medical equipment
- Training that enables the member's employees to deliver services with high levels of quality. Training may be purchased from a variety of sources.
- Vehicle modifications

See Excluded Services for a list of items that may **not** be purchased as individual-directed goods and services.

Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements:

- A business that:
  - Has all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
  - Has current liability and workers' compensation coverage.
- An individual who has all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

All personnel providing individual-directed goods and services shall:

- Be at least 16 years of age; and
- Be able to communicate successfully with the member.

Rates and units of services are determined through negotiation between the member and the service provider as allowed within the individual budget. See Employer Authority for forms and procedures that must be followed to establish an employee relationship and a basis for issuing payment.

The provider of individual-directed goods and services shall:

- Prepare timecards or invoices approved by the Department that identify what services were provided and the time when services were provided.
- Submit invoices and timecards to the financial management service within 30 days from the date when the service was provided.

A member or personal representative who needs to be reimbursed for an item or service under consumer choices option that is preauthorized in the service plan shall complete form 470-5019, *Consumer Choices Option Non-Payroll Reimbursement Request,* and submit the form to the financial management service provider.

Excluded Services

Costs of the following items and services shall **not** be covered by the individual budget:

- Child care services.
- Clothing not related to an assessed medical need.
- Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
- Costs associated with shipping items to the member.
- Experimental and non-FDA-approved medications, therapies, or treatments.
- Goods or services covered by other Medicaid programs.
- Home furnishings such as comforters, linens, or drapes.
- Home repairs or home maintenance.
- Homeopathic treatments.
- Illegal drugs or alcohol.

- Insurance premiums or copayments of any kind, including home insurance, vehicle insurance, etc.
- Items purchased on installment payments.
- Items that are not directly related to meeting the member's disability-related needs.
- Laundry detergent or household cleaning supplies.
- Motorized vehicles.
- Nutritional supplements such as vitamins or herbal supplements.
- Personal entertainment items.
- Repairs and maintenance of motor vehicles.
- Room and board, including rent or mortgage payments.
- School tuition.
- Service animals.
- Services covered by third parties or services that are the responsibility of a non-Medicaid program.
- Sheltered workshop services.
- Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
- Vacation expenses, other than the costs of approved services the member needs while on vacation.

Consumer-Directed Attendant Care

Legal reference:
AIDS: 441 IAC 77.34(8), 78.38(8), 79.1(2)
BI: 441 IAC 77.39(24), 78.43(13), 79.1(2)
Elderly: 441 IAC 77.33(15), 78.37(15), 79.1(2)
HD: 441 IAC 77.30(7), 78.34(7), 79.1(2)
ID: 441 IAC 77.37(21), 78.41(8), 79.1(2)
PD: 441 IAC 77.41(2), 78.46(1), 79.1(2)

Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks that the member would typically do independently if the member were otherwise able. Consumer-directed attendant care services must be cost-effective and necessary to prevent institutionalization.

Members who request consumer-directed attendant care (CDAC) and for whom the interdisciplinary team agrees that CDAC is an appropriate service shall have CDAC included in their service plan.

The member, parent, guardian, or attorney in fact under a durable power of attorney for health care is responsible for:

- Selecting the person or agency that will provide the components of the attendant care services.
- Determining the components of the attendant care services to be provided with the person who is providing the services to the member.
- Completing form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, with the provider and signing it. A copy of this form must be given to the service worker or case manager before the service can begin. Form 470-3372 must be provided to the service worker or case manager before services begin.

NOTE: Each provider that is providing the CDAC service must complete and sign a separate form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*.

Members will give direction and training for activities to maintain independence that are not medical in nature. Licensed nurses and therapists will provide on-the-job training and supervision for skilled activities described on form 470-3372. When CDAC is part of the member's service plan, a copy of the completed form 470-3372 becomes an attachment to and part of the service plan.

The service worker or case manager must review and approve form 470-3372 for appropriateness of the provider's training and experience before the provision of services. (As the state Medicaid agency, the Department of has oversight responsibility for CDAC providers, as for providers of any other home- and community-based waiver services.)

It is recommended that provisions be made for alternate providers to supplement service provision for emergencies that may arise. These alternate providers should be enrolled and designated in the written service plan. This will allow the alternate service providers to assume the service provision immediately whenever necessary.

A unit of service is 1 hour (up to 7 hours), or one 8-hour to 24-hour day provided by an individual or an agency. Service must be billed in whole units.

Covered Services

Legal reference: **AIDS:** 441 IAC 78.38(8)
BI: 441 IAC 78.43(13)
Elderly: 441 IAC 78.37(15)
HD: 441 IAC 78.34(7)
ID: 441 IAC 78.41(8)
PD: 441 IAC 78.46(1)

All consumer-directed attendant care services are supportive services. Non-skilled service activities may include helping the member with any of the following activities:

- Bathing, shampooing, hygiene, and grooming.
- Cognitive tasks such as handling money and scheduling.
- Communication through interpreting and reading services, as well as the use of assistive devices for communication.
- Dressing.
- Going to or returning from a place of employment. NOTE: The cost of transportation for the member is **not** included.
- Housekeeping essential to the member's health care at home.
- Job-related tasks while the member is on the job-site. NOTE: Assistance with understanding or performing the essential job functions is **not** included.

- Meal preparation, cooking, eating and feeding. NOTE: The actual cost of meals is **not** included.
- Medications ordinarily self-administered, including those prescribed by a qualified health care provider, except for antihypertensives, digitalis preparations, mood altering or psychotropic drugs, or narcotics.
- Minor wound care that does not require skilled nursing care.
- Mobility to and from bed or wheelchair, transferring, or ambulating.
- Toilet needs, including bowel, bladder and catheter assistance, which includes emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter.
- Using transportation essential to the health and welfare of the member, but **not** the cost of transportation for the member or the provider.

The service activities may **not** include parenting or child care for or on behalf of the member. CDAC payment does not include the costs of room and board.

The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician:

- Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.
- Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- Colostomy care.
- Intravenous therapy administered by a licensed nurse.
- Monitoring reactions to medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- Parenteral injections required more than once a week.
- Post-surgical nurse-delegated activities under the supervision of the licensed nurse.

- Preparing and monitoring response to therapeutic diets.
- Recording and reporting changes in vital signs to the nurse or therapist.
- Rehabilitation services, including:
  - Ambulation training
  - Behavior modification
  - Bowel and bladder training
  - Range-of-motion exercises
  - Reality orientation
  - Reminiscing therapy
  - Remotivation
  - Respiratory care and breathing programs
  - Restorative nursing services
  - Reteaching the activities of daily living
- Respiratory care, including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- Tube feedings of members unable to eat solid foods.

The licensed nurse or therapist must ensure appropriate assessment, planning implementation, and evaluation. The licensed nurse or therapist must make on-site supervisory visits every two weeks with the provider present.

The cost of the supervision provided by the licensed nurse or therapist must be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the Care for Kids program before accessing the HCBS waiver.

Eligible Providers

Legal reference:
AIDS: 441 IAC 77.34(8)
BI: 441 IAC 77.39(24)
Elderly: 441 IAC 77.33(15)
HD: 441 IAC 77.30(7)
ID: 441 IAC 77.37(21)
PD: 441 IAC 77.41(2)

A public or private agency or an individual working independently as a provider of CDAC must be certified to provide waiver services. The following providers may be certified to provide CDAC service:

- A person who contracts with the member to provide attendant care service and who is:
  - At least 18 years of age.
  - Qualified by training or experience to carry out the member's plan of care following the Department-approved service plan.
  - Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
  - Not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS.
- Agencies authorized to provide similar services through a contract with the Iowa Department of Public Health for local public health services. The agency must provide a current local public health services contract number.
- Home health agencies certified to participate in the Medicare program.
- Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
- Community action agencies.
- Providers certified under an HCBS waiver for supported community living.
- Assisted living programs certified by the Department of Inspections and Appeals.
- Adult day service providers certified by the Department of Inspections and Appeals.

Providers must demonstrate proficiency in delivery of the services included in a member's service plan. Proficiency must be demonstrated through documentation of prior training and experience or a certificate of formal training. All training and experience must be sufficient to protect the health, welfare, and safety of the member.

Area community colleges provide:

- A medication aide course
- Certification or training that includes demonstration of competence for:
  - Transferring
  - Catheter assistance

Each provider must complete form 470-4389, *Consumer-Directed Attendant Care (CDAC) Daily Service Record*, on a daily basis. Service workers and case managers should review this documentation to assure that the member is receiving the service listed in the service plan. The provider is expected to keep copies of this form for up to 5 years.

Relationship to Other Services

Legal reference:
AIDS: 441 IAC 78.38(9), 177.4(2)
BI: 441 IAC 78.43(13), 177.4(2)
Elderly: 441 IAC 78.37(16), 177.4(2)
HD: 441 IAC 78.34(7), 177.4(2)
ID: 441 IAC 78.41(15), 177.4(2)
PD: 441 IAC 78.46(6), 177.4(2)

When a member has a CDAC service, the CDAC provider cannot receive respite services. An alternative CDAC provider may be used to provide the CDAC services.

Members may be eligible for both an HCBS waiver and the State Supplementary Assistance in-home health-related care program when:

- They meet the eligibility requirements of each program and
- Each program provides a different service.

Handle eligibility and client participation according to the rules of the specific program.

CDAC may not be simultaneously reimbursed with waiver supported employment, work activity, sheltered work, supported community living or respite services, or with Medicaid nursing or home health aide services.

When CDAC is provided by an assisted living facility, note the following:

- Each member must be determined by the Iowa Medicaid Enterprise (IME) Medical Services Unit to meet nursing facility or hospital level of care.
- CDAC payment does not include cost of room and board.
- The service worker or Medicaid case manager should be aware of the specific services included in the facility contract and ensure that:
  - Assisted living facility services are not duplicative of CDAC services.
  - Member needs are being addressed.
  - The member's unmet needs are included in the care plan.
- A member has the right to choose another provider of waiver services when living in an assisted living facility.
- The CDAC fee is calculated based on the needs of the member and may differ from person to person.

Counseling

Legal reference: **AIDS:** 441 IAC 77.34(1), 78.38(1), 79.1(2)
HD: 441 IAC 77.30(6), 78.34(6), 79.1(2)

Counseling services are face-to-face nonpsychiatric mental health services necessary for:

- The management of depression,
- Assistance with the grief process,
- Alleviation of psychosocial isolation, and
- Support to cope with a terminal illness.

Counseling services can be provided to the member and caregiver to facilitate home management of the member and prevent institutionalization. NOTE: Counseling services may be provided to the member's caregiver only when included in the member's approved service plan documented in ISIS.

Counseling services may be provided both for the purposes of:

- Training the member's family or other caregiver to provide care, and
- Helping the member and those caring for the member to adjust to the member's disability or terminal condition.

Services must be provided by a mental health professional. Providers may be:

- Certified community mental health centers,
- Licensed or Medicaid enrolled hospices, or
- Accredited mental health services providers.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is one hour.

Payment for group counseling is based on the group rate divided by six, or, if the number of people in the group exceeds six, by the actual number of people who comprise the group.

Day Habilitation

Legal reference: **ID:** 441 IAC 77.37(27), 78.41(14), 79.1(2)

Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration.

Services must enable or enhance the member's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

The following exclusions apply to this service.

- Services shall not be provided in the member's home. EXCEPTIONS:
  - Family training may be provided in the member's home.
  - Services may be provided in a residential care facility where the member lives.
- Services shall not include vocational or prevocational services and shall not involve paid work.
- Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- Services shall not be provided simultaneously with other Medicaid-funded services.

The unit of service may be an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

A family training option is also available. Day habilitation family training services may include training families in treatment and support methodologies or in the care and use of equipment. The unit of service is always an hour. The units of services payable are limited to a maximum of 10 hours per month.

Environmental Modification and Adaptive Devices

Legal reference: CMH: 441 IAC 77.46, 78.52(2), 79.1(2)

Environmental modifications and adaptive devices include items installed or used within the member's home that address specific, documented health, mental health, or safety concerns.

A unit of service is one modification or device. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

A provider that is approved for the same service under another HCBS waiver shall be eligible to enroll for that service under the children's mental health waiver. All providers of children's mental health waiver services must demonstrate the fiscal capacity to provide services on an ongoing basis.

Family and Community Support Services

Legal reference: **CMH:** 441 IAC 77.46, 78.52(3), 79.1(15)“a”(1)

Family and community support services shall support the member and the member’s family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member’s and the family’s social and emotional strength.

Dependent on the needs of the member and the member’s family members individually or collectively, family and community support services may be provided to the member, to the member’s family members, or to the member and the family members as a family unit.

Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member’s interdisciplinary team.

Family and community support services shall incorporate recommended support interventions, which may include the following:

- Developing and maintaining a crisis support network for the member and for the member’s family.
- Modeling and coaching effective coping strategies for the member’s family.
- Building resilience to the stigma of serious emotional disturbance for the member and the family.
- Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.
- Modeling and coaching the strategies and interventions identified in the member’s crisis intervention plan as defined in 441—24.1(225C) for life situations with the member’s family and in the community.
- Developing medication management skills.
- Developing personal hygiene and grooming skills that contributes to the member’s positive self-image.
- Developing positive socialization and citizenship skills.

Family and community support services may include an amount not to exceed $1,500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

- The interdisciplinary team must identify the transportation or therapeutic resource as a support need.
- The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.
- The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.
- The member's Medicaid targeted case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.
- The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

The following components are specifically excluded from family and community support services:

- Vocational services.
- Prevocational services.
- Supported employment services.
- Room and board.
- Academic services.
- General supervision and member care.

A provider that is approved for the same service under another HCBS waiver shall be eligible to enroll for that service under the children's mental health waiver. All providers of children's mental health waiver services must demonstrate the fiscal capacity to provide services on an ongoing basis.

Direct care staff shall meet the following standards:

- Must be at least 18 years of age.
- Must pass child abuse, dependent adult abuse and criminal background screenings before employment.
- May not be a spouse of the member or the parent or stepparent of the member.

Family and community support services providers shall maintain records to:

- Ensure that the transportation and therapeutic resources provided to not exceed the maximum amount authorized; and
- Support the annual cost reporting requirements.

A unit of family and community support services is one hour.

Family Counseling and Training

Legal reference: **BI:** 441 IAC 78.39(21), 78.43(10), 79.1(2)

Family counseling and training services are face-to-face mental health services provided to the member and the family with whom the member lives (or who routinely provides care to the member) to increase the member's or family members capabilities to maintain and care for the member in the community.

Family counseling and training may be provided by:

- Community mental health centers
- Hospices (licensed or certified under Medicare)
- Accredited mental health service providers
- Qualified brain injury professionals

"Family" may include spouse, children, friends, or in-laws of the member. It does not include people who are employed to care for the member.

Counseling may include the use of treatment regimes as specified in the individual treatment plan. Periodic training updates may be necessary to safely maintain the member in the community.

Counseling may include helping the member or family members with:

- Crisis
- Coping strategies
- Stress reduction
- Management of depression
- Alleviation of psychosocial isolation
- Support in coping with the effects of a brain injury

Home and Vehicle Modification

Legal reference:
BI: 441 IAC 77.39(16), 78.43(5), 79.1(2), 79.1(17)
Elderly: 441 IAC 77.33(9), 78.37(9), 79.1(2), 79.1(17)
HD: 441 IAC 77.30(9), 78.34(9), 79.1(2), 79.1(17)
ID: 441 IAC 77.37(17), 78.41(4), 79.1(2), 79.1(17)
PD: 441 IAC 77.41(3), 78.46(2), 79.1(2), 79.1(17)
For all: 441 IAC 79.1(2), 79.1(2), 79.1(17)

Covered home and vehicle modifications are those physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle are excluded except as specifically included below. (Examples include furnaces, fencing, roof repair, or adding square footage to the residence.) Repairs are also excluded.

Only the following modifications are covered:

- Kitchen counters, sink space, cabinets, and special adaptations to refrigerators, stoves, and ovens.
- Bathtubs and toilets to accommodate transfer, bath chairs, special handles and hoses for showerhead, water faucet controls, and accessible showers and sinks.
- Ramps, lifts, turnaround space adaptations, grab bars and handrails, new door openings, pocket doors, and widening of doors, halls, and windows.
- Modification of existing stairs to widen, lower, raise, or enclose open stairs.
- Low-pile carpeting or slip-resistant flooring and exterior hard-surface pathways.

- Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- Heightening of existing garage door opening to accommodate modified van.
- Keyless entry systems, automatic opening device for home or vehicle door, specialized doorknobs and handles, and special door and window locks.
- Fire safety alarm equipment specific for disability.
- Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- Telecommunications device for the deaf.
- Plexiglas replacement for glass windows.
- Installation or relocation of controls, outlets, switches, or motion detectors.
- Air conditioning and air filtering, if medically necessary.
- Heightening of existing garage door opening to accommodate modified van.
- Bath chairs.

A unit of service is the completion of needed modifications or adaptations. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

Service payment is made to the provider following the completion of the approved modifications. All modifications and adaptations must be in accordance with applicable federal, state, and local building and vehicle codes.

Each modification requires three bids to be provided by the home and vehicle modification provider. The bids need to include the cost of parts and labor and anything else included in the bid.

For the **BI** waiver, expenditures are limited to $6,060 per year. Services may be provided by:

- Supported community living providers under the BI or ID waiver.
- Providers participating as a home and vehicle modification provider under another home- and community-based services waiver.
- Community businesses that have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations an submit verification of current liability and workers' compensation insurance.

Approved providers can provide home or vehicle modifications according to the following standards:

- The provider shall obtain a binding contract with community businesses to perform the work at the reimbursement provided by the Department without additional charge.
- At a minimum, the contract shall include:
  - The itemized costs of materials and labor
  - License for work to be completed (electrical, plumbing, HVAC, etc.)
  - Time frame for work completion
  - Employer's liability coverage
  - Worker's compensation coverage
- The business shall provide physical or structural modifications to homes or vehicles according to service descriptions listed above.
- The business (or its parent company or corporation) shall have the necessary legal authority to operate in conformity with federal, state, and local laws and rules.

For the **elderly** waiver, expenditures are limited to $1,010 in the member's lifetime. Modifications may be provided by:

- Area agencies on aging
- Community action agencies
- Providers participating as a home and vehicle modification provider under another home- and community-based services waiver.
- Community businesses that have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations an submit verification of current liability and workers' compensation insurance.

Services must be performed following Department approval of a contract between the supported community living provider and the community business.

For the **HD** waiver, expenditures are limited to $505 per month, not to exceed $6,060 per year. Services may be provided by:

- Area agencies on aging
- Community action agencies
- Providers participating as a home and vehicle modification provider under another home- and community-based services waiver.
- Community businesses that have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations an submit verification of current liability and workers' compensation insurance.

For the **ID** waiver, expenditures are limited to $5,050 in the lifetime of the member. Services may be provided by:

- Supported community living providers under the ID or BI waiver.
- Providers participating as a home and vehicle modification provider under another home- and community-based services waiver.
- Community businesses that have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations an submit verification of current liability and workers' compensation insurance.

For the **PD** waiver, expenditures are limited to $500 per month, not to exceed $6,060 per year. Services may be provided by:

- Providers participating as a home and vehicle modification provider under another home- and community-based services waiver.
- Community businesses that have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations an submit verification of current liability and workers' compensation insurance.

Home-Delivered Meals

Legal reference: **AIDS:** 441 IAC 77.34(6), 78.38(6), 79.1(2)
Elderly: 441 IAC 77.33(8), 78.37(8), 79.1(2)
HD: 441 IAC 77.30(11), 78.34(11), 79.1(2)

Home-delivered meals means meals prepared elsewhere and delivered to a member at the member's residence.

Each meal shall ensure the member receives a minimum of one-third of the daily-recommended dietary allowance, as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

A maximum of 14 meals is allowed per week. A unit of service is a meal. One unit of a liquid supplement is equal to two cans.

For billing purposes, meals are broken down as follows:

- Morning meal
- Noon meal
- Evening meal
- Liquid supplement

The following providers may enroll to provide home-delivered meals:

- Area agencies on aging or their subcontractors
- Community action agencies
- Home care providers
- Home health aide providers
- Hospitals
- Medical equipment and supply dealers
- Nursing facilities
- Restaurants

When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation.

Home Health Aide

Legal reference: **AIDS:** 441 IAC 77.34(2), 78.38(2), 79.1(2)
Elderly: 441 IAC 77.33(3), 78.37(3), 79.1(2)
HD: 441 IAC 77.30(2), 78.34(2), 79.1(2)
ID: 441 IAC 77.37(20), 78.41(6), 79.1(2)

Home health aide services are unskilled medical services that provide direct personal care. This service may include:

- Observation and reporting of physical or emotional needs.
- Assistance with bathing, shampooing (including pediculosis shampooing), or oral hygiene.
- Assistance with toileting.
- Assistance with ambulation.
- Helping a member in and out of bed.
- Reestablishing activities of daily living (including range of motion exercises).
- Assisting with oral medications ordinarily self administered and ordered by a physician (including application of medicinal skin cream).
- In order to complete a full unit of service, performing incidental household services that are essential to the member's health care at home and necessary to prevent or postpone institutionalization.
- For the HD waiver, accompanying a member to medical services or transport to and from school.

Home health aide daily care may be provided for members who are employed or attending school whose disabling conditions require them to be assisted with morning and evening activities of daily living.

Services are to be provided in the home. A unit of service is a visit. Providers must be certified under Medicare.

Home health services **do not** include:

- Homemaker services, such as cooking and cleaning.
- Services that meet the intermittent guidelines under Medicaid.
- Services that are provided under the EPSDT authority.
- Assistance with homework assignments.

Services may not duplicate any regular Medicaid or waiver services provided under the state plan. Home health aide services are available to Medicaid-eligible people under the age of 21 through Care for Kids (EPSDT).

Home health aide services are available to members under the age of 21 through Care for Kids (EPSDT). For members aged 21 or over, the waiver provides coverage for home health aide services that are needed beyond the intermittent home health aide services available through regular Medicaid.

"Intermittent" home health aide services may include up to 28 hours of service per week when services are medically necessary. Intermittent home health aide services must be accessed before waiver home health aide services.

For the **HD** waiver, a nurse may provide home health services in some cases if the health of the member is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

For the **ID** waiver, waiver home health aide services must exceed those activities provided under supported community living. Instruction, supervision, support, or assistance in personal hygiene, bathing, and daily living are activities provided under supported community living.

Homemaker Service

Legal reference: **AIDS:** 441 IAC 77.34(3), 78.38(3), 79.1(2)
Elderly: 441 IAC 77.33(4), 78.37(4), 79.1(2)
HD: 441 IAC 77.30(1), 78.34(1), 79.1(2)

Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. (The person who usually performs these functions for the member may be incapacitated or be occupied providing direct care to the member.)

Components of the service are directly related to the care of the member and include:

- Shopping for basic needs items such as food, clothing or personal care items, or drugs.
- Maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- Accompaniment of the member to medical or psychiatric services or, for children aged 18 and under, to school.
- Planning and preparing balanced meals.

A unit of service is one hour. Providers must be agencies that are:

- Certified as a home health agency under Medicare, or
- Authorized to provide similar services through a contract with the Department of Public Health for local public health services. The agency must provide a current local public health services contract number.

In-Home Family Therapy Services

Legal reference: CMH: 441 IAC 77.46(4), 78.52(4), 79.1(2)

In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

The goal of in-home family therapy is to maintain a cohesive family unit. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

The following agencies may provide in-home family therapy under the children's mental health waiver:

- Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling.
- Licensed mental health professionals (marital and family therapists, mental health counselors, psychologists, or social workers).

The agency must:

- Conduct specified training for all staff.
- Require the presence of experienced staff during direct services provided by staff who have not received orientation and introductory training.
- Support the crisis intervention plan developed by the child's interdisciplinary team.
- Have written policies and procedures for intake, admission, and discharge.

A unit of in-home family therapy service is one hour. Any period less than one hour shall be prorated.

Interim Medical Monitoring and Treatment

Legal reference: **BI:** 441 IAC 77.39(25), 78.43(14), 79.1(2)
HD: 441 IAC 77.30(8), 78.34(8), 79.1(2)
ID: 441 IAC 77.37(22), 78.41(9), 79.1(2)

Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers. These services:

- Provide experiences for each member's social, emotional, intellectual, and physical development.
- Include developmental care and any special services for a member with special needs.
- Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.
- May include supervision during transportation to and from school if not available through other sources.

Services may not duplicate any regular Medicaid or waiver services provided under the state plan. They may be provided only:

- In the member's home,
- In a registered child development home,
- In a licensed child care center, or
- During transportation to and from school.

Services can be used only during the following circumstances for the usual caregiver:

- Employment
- Search for employment
- Academic or vocational training
- Hospitalization
- Physical or mental illness
- Death

When the usual caregiver is experiencing physical or mental illness, document in the case file whether the usual caregiver is unable to care for the child. Base this determination on the usual caregiver's plan of care and on the risk factors to the member if the parent were supervising the member during this time.

The following providers may provide these services:

- Licensed child-care centers
- Registered child-care homes
- Home health agencies certified to participate in the Medicare program
- Supported community living providers under the ID waiver

The provider must be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. This must be determined by the usual caregivers and a licensed medical professional on the member's interdisciplinary team and documented in the service plan.

The staff-to-member ratio shall not be less than one to six. A unit of service is one hour. A maximum of 12 one-hour units of service is available per day.

Mental Health Outreach

Legal reference: Elderly: 441 IAC 77.33(10), 78.37(10), 79.1(2)

Mental health outreach services are services provided in a member's home to identify, evaluate, and provide treatment and psychosocial support. The services can be provided only on the basis of a referral from the member's interdisciplinary team.

Services may be provided by community mental health centers or other accredited mental health providers. A unit of service is 15 minutes. A maximum of 1,440 units per year is allowed.

Nursing Care

Legal reference: **AIDS:** 441 IAC 77.34(4), 78.38(4), 79.1(2)
Elderly: 441 IAC 77.33(5), 78.37(5), 79.1(2)
HD: 441 IAC 77.30(4), 78.34(4), 79.1(2)
ID: 441 IAC 77.37(19), 78.41(5), 79.1(2)

Nursing care services are services provided by licensed agency nurses to members in the home that are ordered by and included in the plan of treatment established by the physician.

The services must be reasonable and necessary to the treatment of an illness or injury. Services should be based on medical necessity of the member and included in the Iowa Board of Nursing scope of practice guidelines.

Providers must be home health agencies certified under Medicare.

"Intermittent" nursing services are available under the state Medicaid plan when services are medically necessary. Intermittent nursing services must be accessed before waiver nursing services.

AIDS and **HD**: A unit of service is one visit.

Elderly: A unit of service is one visit. A maximum of eight nursing visits per month can be provided for members at the intermediate level of care. There is no limit on the maximum visits for members at the skilled level of care.

ID: A unit of service is one hour. A maximum of 10 hours of service per week is covered.

Nutritional Counseling

Legal reference: **Elderly:** 441 IAC 77.33(12), 78.37(12), 79.1(2)
HD: 441 IAC 77.30(12), 78.34(12), 79.1(2)

Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.

A unit of service is 15 minutes. A licensed dietitian must provide the counseling. Services may be provided by:

- A hospital
- A community action agency
- A nursing facility
- A home health agency
- An independent licensed dietitian

Personal Emergency Response System

Legal reference: **BI:** 441 IAC 77.39(17), 78.43(6), 79.1(2)
Elderly: 441 IAC 77.33(2), 78.37(2), 79.1(2)
HD: 441 IAC 77.30(10), 78.34(10), 79.1(2)
ID: 441 IAC 77.37(18), 78.41(3), 79.1(2)
PD: 441 IAC 77.41(4), 78.46(3), 79.1(2)
For all: 441 IAC 79.1(2), 79.1(2)

The personal emergency response system allows a member experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

- An in-home medical communications transceiver,
- A remote, portable activator,
- A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week, and
- Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

A unit of service is a one-time installation fee or one month's service. Maximum units per state fiscal year are the initial installation and 12 months of service.

Prevocational Services

Legal reference: **BI:** 441 IAC 77.39(22), 78.43(11), 79.1(2)
ID: 441 IAC 77.37(26), 78.41(13), 79.1(2)

Prevocational services are services aimed at preparing a member for paid or unpaid employment, but which are not job task oriented. Prevocational services are intended to have a more generalized result, as opposed to vocational training for a specific job or supported employment.

Services are reflected in a habilitative plan that focuses on general habilitation rather than specific employment objectives. Service activities are not primarily directed at teaching specific job skills, but more at generalized habilitative goals. Activities include teaching the member concepts necessary as job readiness skills, such as:

- Following directions
- Attending to tasks
- Task completion
- Problem solving
- Safety and mobility training

Prevocational services do not include services that are otherwise available to the member through a state or local education agency or vocational rehabilitation services.

BI: Providers of prevocational services must meet the Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers.

ID: Providers of prevocational services must be accredited by one of the following:

- The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.
- The Council on Quality and Leadership.

Residential-Based Supported Community Living Services

Legal reference: ID: 441 IAC 77.37(23), 78.41(10), 79.1(2)

Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

Allowable service components are the following:

- **Daily living skills development**. These services develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.
- **Social skills development**. These services develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.
- **Family support development**. These services are necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that:
  - Involve both the child and the child's family at least 50% of the time and
  - Focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.
- **Counseling and behavior intervention services**. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under may include counseling and behavior interventions with the child, including interventions to ameliorate problem behaviors.

Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning and other medical care.

Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid. Room and board costs are not reimbursable as residential-based supported community living services.

The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

The Department contracts only with public or private agencies to provide residential-based supported community living services. Residential-based supported community living services may be provided by:

- Agencies licensed by the Department as foster group care facilities or foster care residential facilities for children with an intellectual disability.
- Other agencies that meet the requirements of 441 IAC 7.37(23)"b"(3).

Eligibility Requirements

Legal reference: ID: 441 IAC 83.61(1)"k"

To be eligible for residential-based supported community living services, a child must:

- Be less than 18 years of age;
- Either:
  - Be residing in an ICF/ID;
  - Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment; **or**
  - Be in long-term placement that is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family and all service options to keep the child in the home have been reviewed by an interdisciplinary team.
- Have an intellectual disability or be a person with a related condition, which is defined as a severe, chronic disability that meets all of the following conditions:

- The condition is manifested before age 22.
- The condition is likely to continue indefinitely.
- The condition is attributable to cerebral palsy, epilepsy, or any condition other than mental illness that is found to be closely related to a person with an intellectual disability because the condition:
  - Results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and
  - Requires treatment or services similar to those required for a person with an intellectual disability.
- The condition results in substantial functional limitations in three or more of the following areas of major life activity:
  - Self-care
  - Understanding and use of language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living

Approval Process

Slots for residential-based supported community living services are separate from the regular ID waiver slots. When considering a child (for this service, the income maintenance worker must request a separate waiver slot, even if the child already has a slot under ID waiver.

After the child has been given a slot for this service, the child must be preapproved by the Bureau of Long-Term Care as appropriate for the service before being enrolled in it.

Requests for approval shall be submitted in writing to the Iowa Medicaid Enterprise, ATTN: Program Manager, 100 Army Post Road, Des Moines, IA 50315. The supporting documentation shall include the following:

- Social history;
- Case history that includes previous placements and service programs;
- Medical history that includes major illnesses and current medications;
- Current psychological evaluations and consultations;

- Summary of all reasonable and appropriate service alternatives that have been tried or considered;
- Any current court orders in effect regarding the child;
- Any legal history;
- Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;
- Whether the proposed placement would be safe for the child and for other children living in that setting; and
- Whether the interdisciplinary team is in agreement with the proposed placement.

Once the child has been approved by the Bureau of Long Term, the case manager or service worker can then proceed with establishing the held in the service.

The funding provided by the waiver covers the cost of the service. The service provider shall furnish living units for all service recipients, but the cost of rent, furnishings, food, and clothing cannot be reimbursed under the waiver. Some of these costs may be covered through SSI, Food Assistance, rent subsidy assistance, parental contribution, etc.

Service Plan

The service plan shall be developed in collaboration with the social worker or case manager, the child, the family, and if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan.

Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.

The service plan shall identify the following:

- Strength and needs of the child.
- Goals to be achieved to meet the needs of the child.
- Objectives for each goal that are specific, measurable and time-limited and include indicators of progress toward each goal.
- Specific service activities to be provided to achieve the objectives.
- The people responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.
- Date of service initiation and date of individual service plan development.
- Service goals describing how the child will be reunited with the child's family and community.

People qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on form 470-4694, *Case Management Comprehensive Assessment*.

Service Plan Review

The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child.

The service plan shall be revised when any of the following occur:

- Service goals or objectives have been achieved.
- Progress toward goals and objectives is not being made.
- Changes have occurred in the identified service needs of the child, as listed on form 470-4694, *Case Management Comprehensive Assessment*.
- The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

When the child reaches age 18, the IME may choose to fund the member in this setting until the person turns 21. If the IME does agree to fund the member, the service code must then be changed from W1320 to W1300 to reflect regular daily supported community living.

NOTE: When the member meets criteria for "other related conditions" and does not have an intellectual disability, the county of legal settlement may not be mandated to provide services to the member as an adult and may choose not to do so. It is recommended that the interdisciplinary team begin strategizing service options for these members at least a year in advance of the member's eighteenth birthday.

Respite Care

Legal reference: **AIDS:** 441 IAC 77.34(5), 78.38(5), 79.1(2)
BI: 441 IAC 77.39(14), 78.43(3), 79.1(2)
CMH: 441 IAC 77.46(5), 78.52(5), 79.1(2)
Elderly: 441 IAC 77.33(6), 78.37(6), 79.1(2)
HD: 441 IAC 77.30(5), 78.34(5), 79.1(2)
ID: 441 IAC 77.37(15), 78.41(2), 79.1(2)

Respite care services are services provided to the member that give temporary relief to the usual caregivers and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable members to remain in their current living situation.

The CMH waiver defines the "usual caregiver" as a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

Respite care is not to be provided to a member during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

Respite services that are not provided in a facility are divided into three types. These types have separate rates of payment based on staff-to-member ratios and member needs, as follows:

- **Basic individual respite** is respite provided on a ratio of one staff to one member. The member does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.
- **Group respite** is respite provided on ratio of one staff to two or more member s receiving respite. These members do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.
- **Specialized respite** is respite provided on a ratio of one or more nursing staff to one member. The member has specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

The interdisciplinary team shall determine whether the member will receive basic individual respite, group respite, or specialized respite as appropriate to the individual needs of the member.

Respite provided outside the member's home or the facility covered by the licensure, certification, accreditation, or contract must:

- Be approved by the parent, guardian, or primary caregiver and the interdisciplinary team.
- Be consistent with the way the location is used by the public.
- Not exceed 72 continuous hours.

For billing purposes, respite in camps is broken down as follows:

- Respite residential camp: week-long overnight recreational
- Group summer day camp: group recreational respite for members requiring additional supports; provided during the day, does not include overnight stays
- Teen day camp: day camp providing recreational activities for teens ages 13 to 21
- Weekend on-site respite: camp-based recreational overnight respite with traditional camp activities

A unit of service is one hour for all respite services. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

Under the **ID** waiver, payment for respite services shall not exceed $7,050 per the member's waiver year. Following is an example of how to amend the ISIS service plan to change respite

Member S has been authorized for $7,050 worth of respite dollars from January 1, 2010, to May 30, 2010. He has not used all of these dollars. Now he wants to go to respite camp and he also needs respite through another provider to finish his waiver year. He needs $4,000 to do this.

On June 1, 2010, the worker must reduce the dollars that were not used from the first period to $3,050, providing this amount was not used during the first period. The worker must contact the ISIS Help Desk to change this amount.

When respite care is provided, the provision of or payment for other duplicative services under the waiver is precluded. Specifically, under the **BI** waiver, respite services shall not be simultaneously reimbursed with other residential or respite services, supported community living services, Medicaid nursing, or Medicaid home health aide services.

Services provided outside the member's home are not reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

Provider Requirements

The following sources may provide respite under each waiver:

AIDS: Respite may be provided by:

- A adult day care provider under the AIDS/HIV waiver
- A camp certified by the American Camping Association
- A child development home registered with DHS
- A child-care center licensed by DHS
- A group living foster care facility for children licensed by DHS
- A home health agency certified to participate in Medicare
- A homemaker service provider under the AIDS/HIV waiver
- A hospital enrolled in Medicaid
- A nursing facility enrolled in Medicaid
- A preschool
- A respite provider under the HCBS ID or BI waiver
- An assisted living program certified by DIA
- An intermediate care facility for people with an intellectual disability (ICF/ID)

BI: Respite providers may be provided by:

- A BI waiver provider
- A camp certified by the American Camping Association
- A child-care center licensed by DHS
- A child development home registered with DHS
- A group living foster care facility for children licensed by DHS
- A home care agency under the HD waiver
- A home health agency certified to participate in Medicare
- A hospital enrolled in Medicaid
- A nursing facility enrolled in Medicaid
- A preschool
- A residential care facility for people with an intellectual disability (RCF/ID)
- A respite provider certified under the HCBS ID waiver
- An adult day care provider certified by DIA
- An intermediate care facility for people with an intellectual disability (ICF/ID)

CMH: Respite may be provided by:

- A camp certified by the American Camping Association
- A child development home registered with DHS
- A child-care center licensed by DHS
- A group living foster care facility for children licensed by DHS
- A home health agency certified to participate in Medicare
- A hospital enrolled in Medicaid
- A nursing facility enrolled in Medicaid
- A residential care facility for people with an intellectual disability (RCF/ID)
- A respite provider certified under another waiver
- An adult day care provider certified by DIA
- An agency with a local public health services contract for similar services
- An assisted living program certified by DIA
- An intermediate care facility for people with an intellectual disability (ICF/ID)

Elderly: Respite may be provided by:

- A camp certified by the American Camping Association
- A home health agency certified to participate in Medicare
- A homemaker service provider under the elderly waiver
- A hospital enrolled in Medicaid
- A nursing facility enrolled in Medicaid
- A respite provider certified under the HCBS ID waiver
- An adult day care provider certified by DIA
- An assisted living program certified by DIA
- An intermediate care facility for people with an intellectual disability (ICF/ID)

HD: Respite may be provided by:

- A camp certified by the American Camping Association
- A child development home registered with DHS
- A child-care center licensed by DHS
- A group living foster care facility for children licensed by DHS
- A home health agency certified to participate in Medicare
- A homemaker service provider under the HD waiver
- A hospital enrolled in Medicaid
- A nursing facility enrolled in Medicaid
- A preschool

- A residential care facility for people with an intellectual disability (RCF/ID)
- A respite provider certified under the HCBS BI or ID waiver
- An adult day care provider certified by DIA
- An assisted living program certified by DIA
- An intermediate care facility for people with an intellectual disability (ICF/ID)

ID: Respite may be provided by:

- A camp certified by the American Camping Association
- A child development home registered with DHS
- A child-care center licensed by DHS
- A group living foster care facility for children licensed by DHS
- A home health agency certified to participate in Medicare
- A hospital enrolled in Medicaid
- A nursing facility enrolled in Medicaid
- A preschool
- A residential care facility for people with an intellectual disability (RCF/ID)
- An adult day care provider certified by DIA
- An agency with a local public health services contract for similar services
- An assisted living program certified by DIA
- An intermediate care facility for people with an intellectual disability (ICF/ID)
- Any agency certified to provide care in a member's home under the ID waiver

NOTE: Respite provided for a period exceeding 24 consecutive hours to three or more people who require nursing care because of a mental or physical condition must be provided by a licensed health care facility.

A facility providing respite shall not exceed its licensed capacity, and services shall be provided in locations consistent with licensure.

Providers shall maintain the following information that shall be updated at least annually:

- The member's name, birth date, age, and address and the telephone number of each parent, guardian, or primary caregiver.
- An emergency medical care release.
- Emergency contact telephone numbers such as the number of the member's physician and the parents, guardian, or primary caregiver.
- The member's medical issues, including allergies.
- The member's daily schedule which includes the member's preferences in activities, food preferences, or any other special concerns.

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

- All medications shall be stored in their original containers, with the accompanying physician or pharmacist's directions and label intact.
- Medications shall be stored so they are inaccessible to members and the public.
- Non-prescription medications shall be labeled with the member's name.
- In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

- Notifying the parent, guardian, or primary caregiver of any injuries or illness that occur during respite provision. A signature by the parent, guardian, or primary caregiver is required to verify receipt of notification.
- Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred before respite provision.
- Documenting activities and times of respite. This documentation shall be made available to the parent, guardian, or primary caregiver upon request.
- Ensuring the safety and privacy of the person. Policies shall at a minimum address fire, tornado, flood and bomb threats.

Senior Companion Services

Legal reference: **Elderly**: 441 IAC 77.33(14), 78.37(14), 79.1(2)

Senior companion services include nonmedical care supervision, oversight, and respite services. Companions may assist with such tasks as meal preparation, laundry, shopping, and light housekeeping tasks. This service cannot provide hands-on nursing or medical care.

Senior companion programs designated by the Corporation for National and Community Service may provide this service. A unit of service is one hour.

Specialized Medical Equipment

Legal reference: **BI:** 441 IAC 77.39(19), 78.43(8), 79.1(2)
PD: 441 IAC 77.41(5), 78.46(4), 79.1(2)

Specialized medical equipment means medically necessary items for personal use by a member that provide for the member's health and safety, such as:

- Electronic aids and organizers
- Medicine dispensing devices
- Communication devices
- Bath aids
- Environmental control units
- Repair and maintenance of items purchased through the waiver

Specialized medical equipment can be covered when it:

- Is identified in the member's approved service plan documented in ISIS.
- Is not ordinarily covered by Medicaid.
- Is not funded by educational or vocational rehabilitation programs.
- Is not provided by voluntary means.
- Is necessary for the member's health and safety, as documented by a health care professional.

The following providers may provide specialized medical equipment:

- Medical equipment and supply dealers participating in the Medicaid program.
- Retail and wholesale businesses participating in the Medicaid program.

Under the **BI** waiver, members may receive specialized medical equipment once per month until a maximum yearly usage of $6,060 has been reached.

Supported Community Living Services

Legal reference: **BI:** 441 IAC 78.39(13), 78.43(2), 79.1(15), 79.1(2)
ID: 441 IAC 77.37(14), 78.41(1), 79.1(15), 79.1(2)

Supported community living services are provided within the member's home and community, according to the individualized member need as identified in the approved service plan documented in ISIS.

Services are individualized supportive services provided in a variety of community-based, integrated settings. Members may live in the home of their family or legal representative or in other types of typical community living arrangements. Members may not live in licensed medical facilities.

Supported community living services are intended to provide for the daily living needs of the member and shall be available on an as needed basis up to 24 hours per day. These services must:

- Be provided in the least restrictive environment possible, and
- Reflect the member's choice of living arrangement and services.

The Department certifies only public or private agencies to provide the supported community living service. The Department does not recognize individuals as service providers under the supported community living program.

Providers meeting the definition of foster care shall also be licensed according to applicable rules for foster care licensing. Providers of service may employ or contract with people meeting the definition of foster family homes to provide supported community living services. These people shall be licensed according to applicable rules for foster care licensing.

At initial enrollment the service worker, Department QIDP, case manager paid by the county without Medicaid funds, or Medicaid case manager will establish an HCBS interdisciplinary team for each member.

With the team, this person will identify the member's need for service, based on the member's needs and desires, as well as the availability and appropriateness of services. The Medicaid case manager must complete an annual review thereafter.

The following criteria are used for the initial and ongoing assessments:

- Members aged 17 or under shall receive services based on development of adaptive, behavioral, or health skills.
- Service plans for member s aged 20 or under must be developed or reviewed after the individual education plan (IEP) and Care for Kids (EPSDT) plan (if applicable) are developed, so as not to replace or duplicate services covered by those plans.
- Service plans for members aged 20 or under which include supported community living services beyond intermittent (52 hours) will not be approved until a home health provider has made a request to cover the service through EPSDT and receives a determination of whether EPSDT is appropriate.
- Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the Bureau of Long-Term Care designee.

  The service worker, Department QIDP, or Medicaid case manager must attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The request must provide a rationale for requesting service beyond intermittent.

  The rationale must contain sufficient information for designee of the Bureau of Long-Term Care or the county board of supervisors to make a decision regarding the need for supported community living beyond intermittent.

Service plans must reflect all appropriate non-waiver Medicaid services so as not to duplicate or replace these services. Services shall not be simultaneously reimbursed with other residential services, waiver respite, or Medicaid or waiver nursing or home health aide services. Under the BI waiver, services shall also not be simultaneously reimbursed with transportation or personal assistance services.

- Services are available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure. This service shall provide supervision or structure in identified periods when another resource is not available.
- Services are available at an hourly rate to members for whom a daily rate is not established. Intermittent service shall be provided from one to three hours a day for no more than four days a week.

Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. Maintenance and room and board costs are not reimbursable.

A unit of service is:

- One full calendar day when:
  - An **ID** member residing in a living unit receives on-site staff supervision for **14** or more hours during a 24-hour calendar day, OR
  - A **BI** member residing in a living unit receives on-site staff supervision for **19** or more hours during a 24-hour calendar day, AND
  - The **BI or ID** member's service plan identifies and reflects the need for this amount of supervision.
- One hour for other situations.

The specific support needs must be identified in the member's service plan. The total costs of supported community living services shall not exceed $1,570 per member per year. The provider must maintain records to support the expenditures.

The maximum numbers of units available per member are as follows:

- **BI or ID**: 365 daily units per state fiscal year except a leap year, when 366 daily units are available.
- **ID**: 5,110 hourly units per state fiscal year except a leap year, when 5,124 hourly units are available.
- **BI**: 8,395 hourly units are available per state fiscal year except a leap year, when 8,418 hourly units are available.

Service Components

The basic components of supported community living service, may include, but are not limited to:

- **Personal and home skill training services** are those activities, which assist a member to develop or maintain skills for self-care, self-directness, and care of the immediate environment.
- **Individual advocacy service** is the act or process of representing a person's rights and interests in order to realize the rights to which the person is entitled and to remove barriers to meeting the person's needs.
- **Community skills training services** are activities, which assist a person to develop or maintain skills, which allow better participation in the community. Services must focus on the following areas as they are applicable to the person being served:
  - **Personal management** skills training services are activities that assist a member to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one's personal business and property. This includes self-advocacy skills.

    Examples of personal management skills are the ability to maintain a household budget, plan, and prepare nutritional meals, use community resources (such as public transportation and libraries), and select foods at the grocery store.
  - **Socialization** skills training services are activities, which assist a member to develop or maintain skills, which include self-awareness, and self-control, social responsiveness, group participation, social amenities, and interpersonal skills.
  - **Communication** skills training services are activities that assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.
- **Personal environment support services** are activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

- **Transportation services** are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The service does **not** exclude transportation to and from work or a day program.
- **Treatment services** are activities designed to assist the member to maintain or improve physiological, emotional, and behavioral functioning, and to prevent conditions that would present barriers to a member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment:
  - Physiological treatment means activities, including medication regimens, designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. These activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the activity specified.
  - Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

Allowable service activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management, or other case management.

Living Arrangements

A member may choose almost any living arrangement. A member may live alone, or with family, friends, other members, or staff. A member may buy or rent a house, trailer, condominium, or an apartment. A member may live in an environment owned by the member, by an agency, or by someone else.

The Department must approve group living units. Living units must be located at scattered sites throughout the community, with regard for community norms in geographical proximity of residences.

Supported Employment Services

Legal reference: **BI:** 441 IAC 77.39(15), 78.43(4), 79.1(2), 79.1(15)
ID: 441 IAC 77.37(14), 78.41(7), 79.1(15)

Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to members:

- For whom competitive employment at or above minimum wage is unlikely, and
- Who need intense and ongoing support to perform in a work setting because of their disability.

Under the ID waiver, a member must be aged 16 or older to receive supported employment services.

Individual placements are the preferred service model. Covered services address the disability-related challenges to securing and keeping a job. They may include:

- Activities to obtain a job
- Supports to maintain employment

Services shall be identified in the member's individualized service plan. Changes in the member's supported employment service or support needs must be reflected in the member's service plan. Changes in the supported employment service result in changes in reimbursement on a quarterly basis.

The case management file for each member must include documentation that this service is not available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142.

Supported employment services may not be simultaneously reimbursed with other supported employment, work activity, or sheltered work services or with Medicaid or HCBS ID waiver respite, nursing or home health aide services.

The following services are **not** covered:

- Supports for volunteer work or unpaid internships,
- Tuition for education or vocational training,
- Individual advocacy that is not member specific, or
- Services involved in placing or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

The Department will contract only with public or private agencies to provide supported employment services. The Department does not recognize individuals as service providers under the supported employment program.

The supported employment provider must provide:

- Individualized and ongoing support contacts at intervals necessary to promote successful job retention.
- Employment-related adaptations required to assist the member with the performance of the job function.

NOTE: If the supported employment provider pays the member, the provider must have written policies that address the following:

- Member vacations, sick leave, and holiday compensation
- Members wage and pay schedules
- Worker's compensation insurance
- Procedures for the determination and review of commensurate wages
- Department of Labor requirements

Activities to Obtain a Job

Activities to obtain a job are services focused on job placement, not on teaching generalized employment skills or habilitative goals. Services must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year.

The following conditions must be met before activities to obtain a job are provided:

- The member's interdisciplinary team must complete the Iowa Vocational Rehabilitation Services form SES/RA-1, *Supported Employment Readiness Analysis*, to identify the supported employment services appropriate to meet the member's employment needs.

  Click here to see the ***Iowa Supported Employment Model (ISEM) Manual***, which contains a sample of this form.

- The interdisciplinary team must determine that the identified services are necessary.
- The Iowa Medicaid Enterprise Medical Services Unit must approve the services.

Components of activities to obtain a job include:

- Job development

  Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. A member may receive two units of job development services during a 12-month period. The activities provided may include:

  - Job procurement training, including grooming and hygiene, application, resume development, interviewing skills, follow-up letters, and job search activities;
  - Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and
  - Customized job development specific to the member.

- Employer development

  Employer development services are focused on supporting employers in hiring and retaining waiver members in their workforce and communicating the expectations of the business to the interdisciplinary team.

  Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week.

  A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for the service may be made only after the member holds the job for 30 days.

  A member may receive two units of employer development during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met.

Employer development services may include:

- Developing relationships with employers;
- Providing leads for individual member s when appropriate;
- Job analysis for a specific job;
- Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities;
- Identifying and arranging reasonable accommodations with the employer;
- Providing disability awareness and training to the employer when it is deemed necessary; and
- Providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

♦ Enhanced job search

Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days or with assisting the member in changing jobs due to lay-off, termination, or personal choice.

The interdisciplinary team must review and update the Iowa Vocational Rehabilitation Services form *Supported Employment Readiness Analysis* to determine if activities to obtain a job remain appropriate for the member's employment goals.

A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

- Job opening identification with the member;
- Assistance with applying for a job, including completion of applications or interviewing; and
- Work site assessment and job accommodation evaluation.

Supports to Maintain Employment

Supports to maintain employment may include:

- Individual work-related behavioral management.
- Job coaching.
- On-the-job or work-related crisis intervention.
- Assistance with communication skills, problem solving, and safety.
- Consumer-directed attendant care services.
- Assistance with time management.
- Assistance with appropriate grooming.
- Employment-related supportive contacts.
- Employment-related transportation to employment and disability.
- On-site vocational assessment after employment.
- Employer consultation.

NOTE: Other forms of community transportation must be attempted before transportation is provided as a supported employment service. (This includes car pools, coworkers, self or public transportation, families, and volunteers.)

Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

Services for maintaining employment may include services associated with sustaining members in a team of no more than eight people with disabilities in a teamwork or “enclave” setting.

A unit of service is one hour. A maximum of 40 units may be received per week.

Transportation

Legal reference: **BI:** 78.39(16), 78.43(7), 79.1(2)
Elderly: 441 IAC 77.33(11), 78.37(11), 79.1(2)
ID: 77.37(24), 78.41(11), 79.1(2)
PD: 441 IAC 78.46(5), 79.1(2)

Transportation services may be provided for members:

- To conduct business errands and essential shopping;
- To receive medical services not reimbursed through medical transportation;
- To travel to and from work or day programs (BI, ID and PD); or
- To reduce social isolation.

A unit of service is either per mile or per trip, or (for Elderly and ID waivers only) a unit established by area agency on aging.

For the PD waiver, a unit of service is either per mile for regional transit providers or per trip when using a rate established by the area agency on aging. Reimbursement will be at the lowest cost service rate consistent with the member's needs.

Transportation may not be reimbursed at the same time as supported community living service unless the cost of transportation is removed from the supported community living rate.

The following providers may provide transportation:

- Community action agencies
- Regional transit agencies
- Nursing facilities
- Area agencies on aging
- Providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services
- (ID only) Transportation providers that have a current contract with county governments
- (ID only) Accredited providers of home- and community-based services