e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The service worker, department QMRP, or Medicaid case manager shall complete the Functional Assessment Tool, Form 470-3073, for the initial level of care determination within 30 days from the date of the HCBS application unless the worker can document difficulty in locating information necessary for completion of Form 470-3073 or other circumstances beyond the worker's control.

g. At initial enrollment the service worker, department QMRP, case manager paid by the county without Medicaid funds, or Medicaid case manager shall establish an HCBS MR interdisciplinary team for each consumer and, with the team, identify the consumer's need for service based on the consumer's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing assessments:

(1) The assessment shall be based, in part, on information on the completed Functional Assessment Tool, Form 470-3073.

(2) Service plans or individual comprehensive plans (ICPs) for consumers aged 20 or under must be developed or reviewed after the individual education plan (IEP) and early periodic screening, diagnosis and treatment (EPSDT) plan, if applicable, are developed so as not to replace or duplicate services covered by those plans.

(3) Service plans or ICPs for consumers aged 20 or under which include supported community living services beyond intermittent shall 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.

(4) Service plans or ICPs for consumers aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the division of medical services, designee or the county board of supervisors' designee. The service worker, department QMRP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the division of medical services' designee or the county board of supervisors' designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) *"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) *HCBS MR program limit.* The number of persons served shall be subject to a limit based on the number of payment slots set forth in the HCBS MR waiver amendment. The department shall make a request to the Health Care Financing Administration (HCFA) to adjust the program limit annually to be effective each July 1 based upon the county management plans submitted by the state and counties. The department shall also submit a request to HCFA for changes to the program limit to be effective January 1 if requested by a county during the month of September.

a. The payment slots are on a county basis for adults with legal settlement in a county and are on a statewide basis for children and adults without a county of legal settlement.

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list shall be sent to the person by the department.

83.61(4) *Securing a payment slot.*

a. The county department office shall contact the division of medical services for state cases and children or the central point of coordination administrator for the county of legal settlement for adults to determine if a payment slot is available for all new applications for the HCBS MR program.

(1) For persons not currently receiving Medicaid, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, or after disability determination, whichever is later.

(2) For current Medicaid recipients, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a signed and dated Form SS-1645-0, Home- and Community-Based Service Report.

(3) A payment slot is assigned to the applicant upon confirmation of an available slot.

(4) Once assigned, written notice shall be given to the applicant, and the payment slot shall be held for the applicant for 180 days to arrange services unless the person has been determined ineligible for the program. If services are not initiated within 180 days of the date on the county department's written notice to the applicant, the slot reverts for use by the next applicant on the waiting list, if applicable. The applicant must reapply for a new slot.

b. On the third day after the receipt of the completed Form PA-1107-0 or SS-1645-0, if no payment slot is available, persons shall be entered on a waiting list by the division of medical services or county according to the following:

(1) Persons not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, is date-stamped in the county department office. Consumers currently eligible for Medicaid shall be added to the waiting list on the basis of the date the consumer requests HCBS MR program services as documented by the date of the consumer's signature on Form SS-1645-0. In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their application rejected, but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list. The county central point of coordination administrator for adults and the division of medical services for children and adults with state case status shall contact the county department when a slot becomes available. If services are not initiated within 180 days of the date on the county department's written notice to the consumer, the slot reverts for use by the next applicant on the waiting list, if applicable.

441—83.62(249A) Application.

83.62(1) *Application for HCBS MR waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS MR waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/MR care. The case manager or worker shall have the consumer or legal representative complete and sign Part E of Form SS-1645, Home and Community Based Service Report, indicating the consumer's choice of care.

d. HCBS MR waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS MR waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

83.62(4) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 30 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form SS-1104-0, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual ICP staffing meeting and the corresponding long-term care need determination.

83.62(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of eligibility for HCBS MR waiver services shall be completed at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS MR waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modifications, supported employment, consumer-directed attendant care services, and interim medical monitoring and treatment services as set forth in rule 441—78.41(249A).

441—83.67(249A) Individual comprehensive plan or service plan. An individual comprehensive plan (ICP) or service plan shall be prepared and utilized for each HCBS MR waiver consumer. The ICP or service plan shall be developed by the interdisciplinary team which includes the consumer and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved. The ICP shall be stored by the case manager for a minimum of three years. The ICP staffing shall be conducted before the current ICP expires. The service plan or ICP shall incorporate the concept of managed care. The plan shall be in accordance with rule 441—24.44(225C) and shall additionally include the following information to assist in evaluating the program:

83.67(1) A listing of all services received by a consumer at the time of waiver program enrollment.

83.67(2) For supported community living consumers the plan shall include identification of:

a. The consumers' living environment at the time of waiver enrollment.

b. The number of hours per day of on-site staff supervision needed by the consumer.

c. The number of other waiver consumers who will live with the consumer in the living unit.

83.67(3) Rescinded IAB 1/4/95, effective 3/1/95.

83.67(4) An identification and justification of any restriction of a consumer's rights including, but not limited to:

a. Maintenance of personal funds.

b. Self-administration of medications.

83.67(5) The name of the service provider responsible for providing the service.

83.67(6) The service funding source.

83.67(7) The amount of the service to be received by the consumer.

83.67(8) Documentation. The Medicaid case manager shall ensure that the consumer's case file contains the consumer's ICP or service plan, the county or department's final approval of services and service costs and the following completed forms:

a. Eligibility for Medicaid Waiver, Form RS-1238.

b. Home- and Community-Based Service Report, Form SS-1645-0.

c. Medicaid Home- and Community-Based Payment Agreement, Form MA-2171.

83.67(9) Approval of plan. The administrator of the division of medical services' designee for children and state cases, or the county board of supervisors' designee for adults, shall review the availability and appropriateness of services as specified in the individual comprehensive plan or service plan and may, based on a written determination, request the individual comprehensive plan or service plan be modified so that the services are cost-effective.

a. A summary of the services and service costs specified in the proposed service plan or ICP must be received and date-stamped by the HCBS MR unit in the department or the county central point of coordination ten working days prior to the planned implementation date.

b. The department or county has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan or ICP unless the parties mutually agree to extend that time frame.

c. If the department or county and service worker or case manager are unable to agree on the terms of the services or service cost within ten days, the department or county has final authority regarding the services and service cost.

d. If a notice of decision is not received from a county within 30 days from the date of request for services, the request shall be sent to the department of human services with documentation verifying the original submission of the request to the county. A letter from the department of human services shall be sent to the county central point of coordination and county board of supervisors requesting a response within ten days. If no response is received within ten days, the division of medical services designee will make the decision as stated in paragraph *"b."*

441—83.68(249A) Adverse service actions.

83.68(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The applicant is not eligible for the services.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The HCBS MR service is not identified in the applicant's individual comprehensive plan (ICP).

f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.

g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.68(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The HCBS MR service is not identified in the consumer's annual ICP.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.

g. The consumer receives services from other Medicaid waiver programs.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or consumer is entitled to have a review of the level of care determination by the Iowa Foundation for Medical Care by sending a letter requesting a review to the foundation. If dissatisfied with that decision, the applicant or consumer may file an appeal with the department.

The applicant or consumer for whom the county has legal payment responsibility shall be entitled to a review of adverse decisions by the county by appealing to the county pursuant to 441—25.21(331). If dissatisfied with the county's decision, the applicant or consumer may file an appeal with the department pursuant to rule 441—83.69(249A).

441—83.70(249A) County reimbursement. The county board of supervisors of the consumer's county of legal settlement shall reimburse the department for all the nonfederal share of the HCBS MR waiver service expenses to adults. The county shall enter into a Medicaid Home- and Community-Based Payment Agreement, Form MA-2171, with the department for reimbursement of the nonfederal share of the cost of service provided to HCBS MR waiver adults.

83.70(1) *County agreement.* The county shall enter into the agreement using the criteria in subrules 83.61(2) and 83.62(1).

83.70(2) *Continuation of services for HCBS MR consumers.* The county shall continue to provide HCBS MR services to consumers with mental retardation who are enrolled in the HCBS MR program on August 1, 1996. The county shall continue to provide HCBS MR services to children who are enrolled in the HCBS MR program after the children turn 18. The state slot for a child in the HCBS MR program will transfer to the county of legal settlement when the child turns 18.

83.70(3) *Continuation of services for HCBS ill and handicapped consumers.* The county shall maintain continuity of services to consumers with mental retardation who are enrolled at the ICF/MR level of care in the HCBS ill and handicapped program at the age of 18.

441—83.71(249A) Conversion to the X-PERT system. For conversion to the X-PERT system at a time other than review, the recipient may be required to provide additional information. To obtain this information, a recipient may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

441—83.72(249A) Rent subsidy program. Recipients of the HCBS MR waiver program may be eligible for a rent subsidy program. See 441—Chapter 53.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to **83.80** Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

"Adaptive" means age appropriate skills related to taking care of one's self and the 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 academics, leisure and work.

"Adult" means a person with a brain injury aged 18 years or over.

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

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

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

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

"Brain injury" means clinically evident damage to the brain 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 neoplasms of brain, cerebrum.

Malignant neoplasms of brain, frontal lobe.

Malignant neoplasms of brain, temporal lobe.

Malignant neoplasms of brain, parietal lobe.

Malignant neoplasms of brain, occipital lobe.

Malignant neoplasms of brain, ventricles.

Malignant neoplasms of brain, cerebellum.

Malignant neoplasms of brain, brain stem.

Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.

Malignant neoplasms of brain, cerebral meninges.

Malignant neoplasms of brain, cranial nerves.

Secondary malignant neoplasm of brain.

Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.

Benign neoplasm of brain and other parts of the nervous system, brain.

Benign neoplasm of brain and other parts of the nervous system, cranial nerves.

Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.

Encephalitis, myelitis and encephalomyelitis.

Intracranial and 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 and contusion.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with a brain injury aged 17 years or under.

"Client participation" means the amount of the consumer's income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

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

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"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 and personal habits.

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

"Individual comprehensive plan (ICP)" (also known as individual program plan) means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It involves more than one provider.

"Individual treatment plan (ITP)" (also known as an individual service plan, individual education plan, and individual habilitation plan) means a written, goal-oriented plan of services developed for a consumer by the consumer and the provider.

"Intermittent supported community living service" means supported community living service provided from one to three hours a day for not more than four days a week.

"Iowa Foundation for Medical Care" is the entity designated by the federal government to be the peer review organization for the state of Iowa.

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

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for the mentally retarded, or hospital which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer 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 consumer's plan of care.

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

"Organization" means the entity being certified.

"Organizational outcome" means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

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

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

"Process" means service or support provided by an agency to a consumer that will allow the consumer 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.

"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.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

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

"Third-party payments" means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

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

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of brain injury.

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution; or be eligible for medically needy.

c. Be aged 1 month to 64 years.

d. Be a U.S. citizen and Iowa resident.

e. Be currently a resident of a medical institution and have been for at least 30 consecutive days at the time of initial application for the brain injury waiver.

f. Be determined by the Iowa Foundation for Medical Care as in need of intermediate care facility for the mentally retarded (ICF/MR), skilled nursing, or ICF level of care.

g. Be assessed by the Iowa Foundation for Medical Care as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.

h. At a minimum, receive a waiver service each quarter.

i. Choose HCBS.

j. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

83.82(2) *Need for services.*

a. The consumer shall have an individual comprehensive plan approved by the department which is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed prior to services provision and annually thereafter.

The case manager shall establish the interdisciplinary team for the consumer, and with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the Iowa Foundation for Medical Care.

(2) Individual comprehensive plans (ICPs) for consumers aged 20 or under must be developed or reviewed after the child's individual education plan (IEP) and early periodic screening, diagnosis and treatment (EPSDT) plan, if applicable, are developed so as not to replace or duplicate services covered by those plans.

(3) ICPs for consumers aged 20 or under which include supported community living services beyond intermittent shall 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.

(4) ICPs for consumers aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the division of medical services designee. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the ICP. The rationale must contain sufficient information for the division of medical services designee, or for an ICF/MR level of care consumer, the designee of the county of legal settlements board of supervisors, to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

d. The total monthly cost of brain injury waiver services shall not exceed $2,650 per month.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Access to HCBS BI waiver services for adult persons meeting the ICF/MR level of care shall be limited to persons who are residing in an ICF/MR and who have resided there for at least 30 days immediately preceding waiver application. In addition, waiver slots for these persons shall be identified in the county management plan submitted to the department pursuant to 441—Chapter 25. Each county shall inform the department regarding the number of payment slots desired by April 1 and October 1 of each year. A county may choose to establish no payment slots under the HCBS BI waiver.

a. The payment slots shall be on a county basis for adults with legal settlement in a county and on a statewide basis for children and adults without a county of legal settlement.

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

83.82(4) *Securing a payment slot.*

a. The county department office shall contact the division of medical services for state cases and children or the county of legal settlement for adults to determine if a payment slot is available for all new applications for the HCBS BI waiver program which require the ICF/MR level of care.

(1) For persons not currently receiving Medicaid, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance.

(2) For current Medicaid recipients, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a signed and dated Form SS-1645-0, Home- and Community-Based Service Report.

b. On the third day after the receipt of the completed Form PA-1107-0 or SS-1645-0, if no payment slot is available, persons shall be entered on a waiting list by the division of medical services or county according to the following:

(1) Persons not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, is date-stamped in the county department office. Consumers currently eligible for Medicaid shall be added to the waiting list on the basis of the date the consumer requests HCBS BI program services as documented by the date of the consumer's signature on Form SS-1645-0. In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

The county shall have financial responsibility for the state share of the costs of services for these consumers as stated in rule 83.90(249A). The county shall include these ICF/MR level of care brain-injured consumers in their annual county management plan which is approved by the state.

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application. The discharge planner shall provide to the Iowa Foundation for Medical Care (IFMC) review coordinator all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IFMC review coordinator shall inform the discharge planner on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. A consumer shall be given the choice between waiver services and institutional care. The consumer or legal representative shall complete and sign Form 470-0660, Home- and Community-Based Service Report, indicating the consumer's choice of caregiver. This shall be arranged by the medical facility discharge planner.

d. The medical facility discharge planner shall contact the appropriate case manager for the consumer's county of residence to initiate development of the consumer's ICP and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

83.83(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by IFMC to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form SS-1104-0, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment services, adult day care, consumer-directed attendant care services, and interim medical monitoring and treatment services as set forth in rule 441—78.43(249A).

441—83.87(249A) Individual comprehensive plan. An individualized comprehensive plan (ICP) shall be prepared and utilized for each HCBS BI waiver consumer. The ICP shall be developed by an interdisciplinary team which includes the consumer and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The ICP shall be stored by the case manager for a minimum of three years. The ICP staffing shall be conducted before the current ICP expires.

83.87(1) *Information in plan.* The plan shall be in accordance with rule 441—24.44(225C) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. For supported community living consumers the plan shall include identification of:

(1) The consumers' living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the consumer.

(3) The number of other waiver consumers who will live with the consumer in the living unit.

c. An identification and justification of any restriction of a consumer's rights including, but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The names of all providers responsible for providing all services.

e. All service funding sources.

f. The amount of the service to be received by the consumer.

83.87(2) *Case plans for consumers aged 20 or under.* Case plans or individual comprehensive plans (ICPs) for consumers aged 20 or under must be developed or reviewed after the child's individual education plan (IEP) and early periodic screening, diagnosis and treatment plans (EPSDT) plan, if applicable, are developed so as not to replace or duplicate services covered by those programs.

Case plans or ICPs for consumers aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the division of medical services designee, or when a county voluntarily chooses to participate, by the county board of supervisors, designee or the division of medical services designee. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) *Annual assessment.* The Iowa Foundation for Medical Care shall assess the consumer annually and certify the consumer's need for long-term care services. The Iowa Foundation for Medical Care shall be responsible for determining the level of care based on the completed Brain Injury Waiver Functional Assessment, Form 470-3283, and supporting documentation as needed.

83.87(4) *Case file.* The Medicaid case manager must ensure that the consumer case file contains the consumer's ICP and, if the county is voluntarily participating, the county's final approval of service costs and the following completed forms:

a. Eligibility for Medicaid Waiver, Form 470-0563.

b. Home- and Community-Based Service Report, Form 470-0660.

c. Medicaid Home- and Community-Based Payment Agreement, Form 470-0379.

d. Consumer Data Entry, Form 470-3280.

441—83.88(249A) Adverse service actions.

83.88(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The brain injury waiver service is not identified in the consumer's individual comprehensive plan (ICP).

f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

g. The consumer receives services from other Medicaid waiver providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.88(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The brain injury service is not identified in the consumer's annual ICP.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.

g. The consumer receives services from other Medicaid providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or consumer is entitled to have a review of the level of care determination by the Iowa Foundation for Medical Care by sending a letter requesting a review to the foundation. If dissatisfied with that decision, the consumer may file an appeal with the department.

The applicant or consumer for whom the county has legal payment responsibility shall be entitled to a review of adverse decisions by the county by appealing to the county pursuant to rule 441—25.21(331). If dissatisfied with the county's decision, the applicant or consumer may file an appeal with the department.

441—83.90(249A) County reimbursement. The county board of supervisors of the consumer's county of legal settlement shall reimburse the department for all the nonfederal share of the cost of brain injury waiver services to persons at the ICF/MR level of care with legal settlement in the county who are coming onto the waiver from a minimum 30-day residence in an ICF/MR facility for which the county has been financially responsible. The county shall enter into a Medicaid Home and Community Based Payment Agreement, Form MA-2171, with the department for reimbursement of the nonfederal share of the cost of services provided to HCBS brain injury waiver adults at the ICF/MR level of care who meet the criteria stated above.

The county shall enter into the agreement using the criteria in subrule 83.82(2).

441—83.91(249A) Conversion to the X-PERT system. For conversion to the X-PERT system at a time other than review, the consumer may be required to provide additional information. To obtain this information, a consumer may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.92 to **83.100** Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and the 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 academics, leisure and work.

"Adult" means a person with a physical disability aged 18 years to 64 years.

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

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

"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 sociosexual behavior.

"Client participation" means the amount of the consumer's income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Department" means the Iowa department of human services.

"Guardian" means a guardian appointed in probate court for an adult.

"Iowa Foundation for Medical Care" is the entity designated by the federal government to be the peer review organization for the state of Iowa.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for the mentally retarded, or hospital which has been approved as a Medicaid vendor.

"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.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It may involve more than one provider.

"Third-party payments" means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

"Waiver year" means a 12-month period commencing on April 1 of each year.

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a physical disability.

b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the division of medical services. Disability determinations are made according to supplemental security income guidelines as per Title XVI of the Social Security Act.

c. Be ineligible for the HCBS MR waiver.

d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a guardian named by probate court who will take this responsibility on behalf of the consumer.

e. Be eligible for Medicaid under 441—Chapter 75.

f. Be aged 18 years to 64 years.

g. Be a current resident of a medical institution and have been a resident for at least 30 consecutive days at the time of initial application for the physical disability waiver.

EXCEPTION: During any waiver year, up to ten persons, two per departmental region as established in 441—subrule 1.4(2), in need of the skilled nursing facility or intermediate care facility level of care who are not residents of a medical institution at the time of application may receive HCBS physical disability waiver services as provided in subrule 83.102(3).

h. Be in need of skilled nursing or intermediate care facility level of care. Initial decisions on level of care shall be made for the department by the Iowa Foundation for Medical Care (IFMC) within two working days of receipt of medical information. After notice of an adverse decision by IFMC, the Medicaid applicant or recipient or the applicant's or recipient's representative may request reconsideration by IFMC pursuant to subrule 83.109(2). On initial and reconsideration decisions, IFMC determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2). Adverse decisions by IFMC on reconsiderations may be appealed to the department pursuant to 441—Chapter 7 and rule 441—83.109(249A).

i. Choose HCBS.

j. Use a minimum of one unit of consumer-directed attendant care service or personal emergency response system service each quarter.

83.102(2) *Need for services.*

a. The consumer shall have a service plan which is developed by the consumer and a department service worker. This must be completed and approved prior to service provision and at least annually thereafter.

The service worker shall identify the need for service based on the needs of the consumer as well as the availability and appropriateness of services.

b. The total monthly cost of physical disability waiver services shall not exceed $621 per month.

83.102(3) *Slots.* The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. Of these, ten slots during any waiver year (two in each departmental region) shall be reserved for persons who were not residents of a medical institution at the time of initial application for the physical disability waiver as allowed by the exception under paragraph 83.102(1)*"g."* These slots shall be available on a first-come, first-served basis.

83.102(4) *County payment slots for persons requiring the ICF/MR level of care.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) *Securing a slot.*

a. The county department office shall contact the division of medical services for all cases to determine if a slot is available for all new applications for the HCBS physical disability waiver program.

(1) For persons not currently receiving Medicaid, the county department office shall contact the division of medical services by the end of the second working day after receipt of a completed Form 470-0442, Application for Medical Assistance or State Supplementary Assistance, submitted on or after April 1, 1999.

(2) For current Medicaid recipients, the county department office shall contact the division of medical services by the end of the second working day after receipt of a signed and dated Form 470-0660, Home- and Community-Based Service Report, submitted on or after April 1, 1999.

b. On the third day after the receipt of the completed Form 470-0442 or 470-0660, if no slot is available, the division of medical services shall enter persons on the HCBS physical disabilities waiver state waiting list for institutionalized persons or on a regional waiting list for the slots reserved for persons who are not institutionalized according to the following:

(1) Persons not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-0442, Application for Medical Assistance or State Supplementary Assistance, is submitted on or after April 1, 1999, and date-stamped in the county department office. Consumers currently eligible for Medicaid shall be added on the basis of the date the consumer requests HCBS physical disability program services as documented by the date of the consumer's signature on Form 470-0660 submitted on or after April 1, 1999. In the event that more than one application is received on the same day, persons shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the state waiting list for institutionalized persons or on a regional waiting list for the slots reserved for persons who are not institutionalized. As slots become available, persons shall be selected from the waiting lists to maintain the number of approved persons on the program based on their order on the waiting lists.

83.102(6) *Securing a county payment slot.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) *HCBS physical disability waiver waiting lists.* When services are denied because the statewide limit for institutionalized persons is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a statewide waiting list shall be sent to the person by the department.

When services are denied because the two slots per region for persons already residing in the community at the time of application are filled, a notice of decision denying service based on the limit on those slots and stating that the person's name shall be put on a waiting list by region for one of the community slots shall be sent to the person by the department.

441—83.103(249A) Application.

83.103(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) *Approval of application for eligibility.*

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application. The discharge planner shall complete Form 470-3502, Physical Disability Waiver Assessment Tool, and submit it to the Iowa Foundation for Medical Care (IFMC) review coordinator. After completing the determination of the level of care needed by the applicant, the IFMC review coordinator shall inform the income maintenance worker and the discharge planner on behalf of the applicant or the applicant's guardian of its decision.

b. Applications for this waiver shall be initiated by the applicant or by the applicant's legal guardian on behalf of the applicant who is residing in the community. The applicant or the applicant's legal guardian shall complete Form 470-3502, Physical Disability Waiver Assessment Tool, and submit it to the Iowa Foundation for Medical Care (IFMC) review coordinator. After completing the determination of the level of care needed by the applicant, the IFMC review coordinator shall inform the income maintenance worker and the applicant or the applicant's legal guardian.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the consumer or the consumer's legal guardian on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant shall complete and sign Form 470-0660, Home- and Community-Based Service Report, indicating the consumer's choice of caregiver.

e. The consumer or the consumer's guardian shall cooperate with the service worker in the development of the service plan, which must be approved by the department service worker prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

83.103(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.102(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.102(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.102(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by IFMC to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by IFMC or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application.

441—83.104(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) *Computation of client participation.* Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

441—83.106(249A) Allowable services. The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation service, and specialized medical equipment as set forth in rule 441—78.46(249A).

441—83.107(249A) Individual service plan. An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer and the DHS service worker prior to services beginning and payment being made to the provider. The plan shall be reviewed by the consumer and the service worker annually, and the current version approved by the service worker.

83.107(1) *Information in plan.* The plan shall be in accordance with 441—subrule 24.2(2) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. The name of all providers responsible for providing all services.

c. All service funding sources.

d. The amount of the service to be received by the consumer.

83.107(2) *Annual assessment.* The Iowa Foundation for Medical Care shall review the consumer's need for continued care annually and recertify the consumer's need for long-term care services, pursuant to the standards and subject to the reconsideration and appeal processes at paragraph 83.102(1)*"h"* and rule 441—83.109(249A), based on the completed Form 470-3502, Physical Disability Waiver Assessment Tool, and supporting documentation as needed. Form 470-3502 is completed by the service worker at the time of recertification.

83.107(3) *Case file.* The consumer case file shall contain the following completed forms:

a. Eligibility for Medicaid Waiver, Form 470-0563.

b. Home- and Community-Based Service Report, Form 470-0660.

c. Medicaid Home- and Community-Based Payment Agreement, Form 470-0379.

d. HCBS Consumer-Directed Attendant Care Agreement, Form 470-3372, when consumer-directed attendant care services are being provided.

e. The service plan.

f. Rescinded IAB 10/6/99, effective 10/1/99.

441—83.108(249A) Adverse service actions.

83.108(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. All of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The physical disability waiver service is not identified in the consumer's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

g. The consumer receives services from other Medicaid waiver providers.

h. The consumer or legal representative requests termination from the services.

83.108(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.108(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The physical disability waiver service is not identified in the consumer's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.

g. The consumer receives services from other Medicaid providers.

h. The consumer or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

83.109(1) *Appeal to county.* The applicant or consumer for whom a county has legal payment responsibility shall be entitled to a review of adverse decisions by the county by appealing to the county pursuant to rule 441—25.21(331). If dissatisfied with the county's decision, the applicant or consumer may file an appeal with the department.

83.109(2) *Reconsideration request to Iowa Foundation for Medical Care (IFMC).* After notice of an adverse decision by IFMC on the level of care requirement pursuant to paragraph 83.102(1)*"h,"* the Medicaid applicant or recipient or the applicant's or recipient's representative may request reconsideration by IFMC by sending a letter requesting a review to IFMC not more than 60 days after the date of the notice of adverse decision. Adverse decisions by IFMC on reconsiderations may be appealed to the department pursuant to 441—Chapter 7.

a. If a timely request for reconsideration of an initial denial determination is made, IFMC shall complete the reconsideration determination and send written notice including appeal rights to the Medicaid applicant or recipient and the applicant's or recipient's representative within ten working days after IFMC receives the request for reconsideration and a copy of the medical record.

b. If a copy of the medical record is not submitted with the reconsideration request, IFMC will request a copy from the facility within two working days.

c. The notice to parties. Written notice of the IFMC reconsidered determination will contain the following:

(1) The basis for the reconsidered determination.

(2) A detailed rationale for the reconsidered determination.

(3) A statement explaining the Medicaid payment consequences of the reconsidered determination.

(4) A statement informing the parties of their appeal rights, including the information that must be included in the request for hearing, the locations for submitting a request for an administrative hearing, and the time period for filing a request.

d. If the request for reconsideration is mailed or delivered to IFMC within ten days of the date of the initial determination, any medical assistance payments previously approved will not be terminated until the decision on reconsideration. If the initial decision is upheld on reconsideration, medical assistance benefits continued pursuant to this rule will be treated as an overpayment to be paid back to the department.

441—83.110(249A) County reimbursement. Rescinded IAB 10/6/99, effective 10/1/99.

441—83.111(249A) Conversion to the X-PERT system. For conversion to the X-PERT system at a time other than review, the consumer may be required to provide additional information. To obtain this information, a consumer may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

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