Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 83
"Medicaid Waiver Services"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249A; 2005 Iowa Acts, chapter 167, section 13; and 2005 Iowa Acts, chapter 117, section 3

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

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Purpose and Summary

The purpose of this proposed chapter is to describe and outline the provision of services under the Medicaid waiver program. Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in a medical institution, including support for persons to seek and maintain employment in the community. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients since the services are beyond the scope of the Medicaid State plan.

This proposed chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result of its review, the Department deleted redundant, restrictive, and outdated language and added dates certain.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this proposed rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Iowans eligible for or receiving services under one of Iowa's Medicaid waiver programs will benefit from this proposed rulemaking.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

There are almost 30,000 Iowans receiving medical services provided under Iowa's Medicaid waiver programs.

- **Qualitative description of impact:**

The almost 30,000 Iowans receiving medical services provided under Iowa's Medicaid waiver programs may not otherwise be able to receive medical services without the waiver programs.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs to implement this proposed chapter.

- **Anticipated effect on State revenues:**

The proposed rulemaking has no impact on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Rulemaking is both appropriate and required by law.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Not applicable.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 83 and adopt the following **new** chapter in lieu thereof:

CHAPTER 83
MEDICAID WAIVER SERVICES

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

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

"Client participation" means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

"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 guidelines.

"Disabled" means an individual is unable to engage in any substantial gainful activity by reason of any 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.

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

"Guardian" means a guardian appointed in probate court.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the DSM or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"MCO"* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"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 a nursing facility or an intermediate care facility for persons with an intellectual disability that has been approved as a Medicaid vendor.

"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 an individual who has been determined to be eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, the member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"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.

"Third-party payment" means payment from an attorney, individual, institution, corporation, 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 medical assistance.

"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.

441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) *Eligibility criteria.*

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act as amended to July 1, 2026.

b. Reserved.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on a completed information submission tool for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 to 64 and other supporting documentation as relevant. The information submission tool, the interRAI - PEDS-HC and the interRAI - HC are available upon request from Iowa Medicaid. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

(1) The member's designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in 441—paragraph 90.4(1)*"b."*

(2) Iowa Medicaid will be responsible for the initial determination of the member's level of care certification. Iowa Medicaid or the member's MCO will be responsible for annual redetermination of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The MCO must submit documentation to Iowa Medicaid for all reassessments, performed at least annually, that indicate a change in the member's level of care. Iowa Medicaid will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. To be eligible for interim medical monitoring and treatment services the member 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 member is eligible must be maximized before the member accesses interim medical monitoring and treatment.);

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

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified in 441—paragraphs 75.82(2)*"b"* and 75.82(4)*"c"* will be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) *Need for services.*

a. The member shall have a service plan approved by the department that is developed by the designated case manager. This service plan must be completed prior to services provision and annually thereafter.

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

(1) This service plan will be based, in part, on information in the completed information submission tool listed in paragraph 83.2(1)*"d"* and other supporting documentation as relevant. The designated case manager will have a face-to-face visit with the member at least quarterly.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The designated case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services will not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

Skilled level of care	Nursing level of care	ICF/ID
$3,014.69	$1,035.79	$4,040.52

For members enrolled in the health and disability waiver in accordance with subrule 83.2(1), when a member turns 21 years of age, the average monthly cost of services received through 441—subrule 78.9(10) will be used to increase the monthly waiver budget in accordance with the following:

(1) The member must request the revised waiver budget through the member's case manager no earlier than two months before, and no later than six months after, the member's twenty-first birthday. A renewal request must be received annually no earlier than two months before, and no later than six months after, each subsequent birthday.

(2) The member's waiver budget will be increased by the average monthly cost of state plan private duty nursing or personal care services for the member that was billed to and paid by Iowa Medicaid or an Iowa Medicaid-contracted MCO during the year in which the member is 20 years of age.

(3) Once the request is received by the department, the department will determine the average monthly cost pursuant to the claims data available at the time of the request. No subsequent claims data shall be considered.

(4) The revised waiver budget reflecting the average cost of state plan private duty nursing or personal care services will become effective on the later of the first day of the month of the member's twenty-first birthday or the first day of the month of the completed review.

(5) The revised waiver budget will extend up to the first of the month following the member's twenty-fifth birthday and will remain at the initially authorized amount for the member while aged 21 through 24.

c. 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 will be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. 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 will 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.

441—83.3(249A) Application.

83.3(1) *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver will be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant's name will be placed on a waiting list maintained by Iowa Medicaid.

a. The department field office will enter all waiver applications into the institutional and waiver service and narrative system (IoWANS) to determine whether a payment slot is available.

(1) For applicants not currently receiving Medicaid, the department field office will make the entry by the end of the fifth working day after receipt of a completed application for health coverage and help paying costs or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the department field office will make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

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

(4) Once a payment slot is assigned, the department field office will give written notice to the applicant. The department will 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 will 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.

b. If no payment slot is available, the department will enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid will be entered on the waiting list on the basis of the date a completed application for health coverage and help paying costs is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid will be added to the waiting list on the basis of the date a request as specified in subparagraph 83.3(2)*"a"*(2) is received by the department.

(3) 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.

(4) Applicants who do not fall within the available slots will have their application rejected, and their names will be maintained on the waiting list. They will be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. Iowa Medicaid will contact the department field office when a slot becomes available.

(5) Once a payment slot is assigned, the department field office will give written notice to the person within five working days. The department will 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 will 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.

c. The department field office will notify Iowa Medicaid within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) *Approval of application.*

a. Applications for the HCBS health and disability waiver program will be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information that is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the required assessment has been submitted to Iowa Medicaid.

(5) The application is pending because the required assessment has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, the application will be denied.

b. Decisions will be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) *Effective date of eligibility.*

a. Deeming of parental or spousal income and resources ceases and eligibility will be effective on the date the income and resource eligibility and level of care determinations are completed but will not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4)*"a"* and *"c"* do not apply is the date on which the income eligibility and level of care determinations are completed.

c. Eligibility for persons covered under subparagraph 83.2(1)*"c"*(3) will exist on the date the income and resource eligibility and level of care determinations are completed but will not be earlier than the first of the month following the date of application.

d. Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care. Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care will be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through a notice of decision. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(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 will 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 will be applied to the waiver application.

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) *Maintenance needs of the individual.* The maintenance needs of the individual will be computed by deducting an amount that is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid will make no payments to health and disability waiver service providers. However, Medicaid will make payments to other medical vendors, as applicable.

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.17(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

83.5(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.5(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with 441—paragraph 90.4(1)*"b."* Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.7(1) The service plan shall include the frequency of the health and disability waiver services and the types of providers that will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the member; and

b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services will be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

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

c. Service needs exceed the aggregate monthly costs established in paragraph 83.2(2)*"b,"* or are not met by the services provided.

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

83.8(2) Termination. A particular service may be terminated when the department determines that:

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

b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in paragraph 83.2(2)*"b."*

c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 120 days in any one stay for purposes other than respite care.

d. The member receives health and disability waiver services and 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 designated case manager.

e. Service providers are not available.

83.8(3) Reduction of services will apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

441—83.9(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 7.

441—83.10 to **83.20** Reserved.

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

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

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

"Case management" means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, and community-based case management provided through managed care.

"Case manager" means the staff person providing all categories of case management services regardless of the entity providing the service or the program in which the member is enrolled.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

"Guardian" means a guardian appointed in probate court.

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

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"MCO"* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Medical institution" means a nursing facility that has been approved as a Medicaid vendor.

"Member" means an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Third-party payment" means payment from an individual, institution, corporation, 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 medical assistance.

"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.

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) *Eligibility criteria.* All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.

b. A resident of the state of Iowa.

c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified in 441—paragraphs 75.82(2)*"b"* and 75.82(4)*"c"* will be applied.

d. Certified as being in need of the intermediate or skilled level of care based, in part, on information submitted on the interRAI - Home Care (HC). The interRAI - HC is available on request from the department and other supporting documentation as relevant. Copies of the completed interRAI - HC for an individual are available to that individual from the individual's case manager or MCO.

(1) The assessment will be completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care. The department will be responsible for determination of the initial level of care.

(2) The department or the member's MCO will be responsible for annual redetermination of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. Determined to need services as described in subrule 83.22(2).

f. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) *Need for services, service plan, and cost.*

a. Case management. Members under the elderly waiver will receive case management services from a provider qualified pursuant to rule 441—77.38(249A). Case management services will be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Interdisciplinary team. The case manager will establish an interdisciplinary team for the member.

(1) Composition. The interdisciplinary team will include the case manager and the member and, if appropriate, the member's legal representative, family, service providers, and others directly involved in the member's care.

(2) Role. The team will identify:

1. The member's need for services based on the member's needs and desires.
2. Available and appropriate services to meet the member's needs.
3. Health and safety issues for the member that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.
4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the member's needs change.

c. Service plan. An applicant for elderly waiver services will have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan will be appropriate to the problems and specific needs or disabilities of the member.

(2) Services must be the least costly available to meet the service needs of the member.

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the member's needs.

d. Content of service plan. The service plan will include the following information based on the member's current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

(3) Incremental action steps, as appropriate.

(4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the member received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.
2. The funding source for the service.
3. The amount of service that the member is to receive.

(9) Indication of whether the member has elected the consumer choice option and, if so, the independent support broker and the financial management service that the member has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the member in situations for which no approved service plan exists and that, if not addressed, may result in injury or harm to the member or other persons or in significant amounts of property damage. Emergency plans will include:

1. The member's risk assessment and the health and safety issues identified by the member's interdisciplinary team.

2. The emergency backup support and crisis response system identified by the interdisciplinary team.

3. Emergency, backup staff designated by providers for applicable services.

441—83.23(249A) Application.

83.23(1) *Application for HCBS elderly waiver.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.23(2) *Approval of application.*

a. Applications for the elderly waiver program will be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision will be made as soon as possible.

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

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool specified in paragraph 83.22(1)*"d,"* indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(3) *Effective date of eligibility.*

a. The effective date of eligibility is the date on which the income eligibility and level of care determinations are completed.

b. Eligibility for persons whose income exceeds supplemental security income guidelines will not exist until the persons require care in a medical institution for a period of 30 consecutive days and will be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care will be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through a notice of decision. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(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 will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) *Computation of client participation.* Client participation will be computed by deducting an amount for the maintenance needs of the individual that is 300 percent of the maximum supplemental security income (SSI) grant for an individual from the client's total income.

83.24(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services will be done at least once every 12 months. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination will contain the components listed in rule 441—83.27(249A).

83.25(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.25(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

441—83.27(249A) Service plan. The service plan will be completed jointly by the member, the elderly waiver case manager, and any other person identified by the member.

83.27(1) The service plan will indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan will identify:

a. The independent support broker selected by the member; and

b. The financial management service selected by the member.

83.27(2) The service plan will identify a plan for emergencies and the supports available to the member in an emergency.

441—83.28(249A) Adverse service actions.

83.28(1) *Denial.* An application for services will be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the elderly waiver services are not needed on a regular basis.

c. Service needs are not met by services provided.

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

83.28(2) *Termination.* A particular service may be terminated when the department determines that:

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

b. The client receives care in a hospital or nursing facility for 120 days in any one stay for purposes other than respite care.

c. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the case manager and the interdisciplinary team.

d. Service providers are not available.

83.28(3) Reduction of services will apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

441—83.29(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal shall be given in accordance with 441—Chapter 7.

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management will cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person's primary diagnosis will determine which services will be used.

441—83.31 to **83.40** Reserved.

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

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

"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."

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

"Case management" means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, and community-based case management provided through managed care.

"Case manager" means the staff person providing all categories of case management services regardless of the entity providing the services or the program in which the member is enrolled.

"Client participation" means the amount of the recipient's income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

"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 guidelines.

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

"Guardian" means a guardian appointed in probate court.

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

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"MCO"* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Medical institution" means a nursing facility or hospital that has been approved as a Medicaid vendor.

"Member" means an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Third-party payment" means payment from an attorney, individual, institution, corporation, 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 medical assistance.

"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.

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based, in part, on information submitted on a completed information submission tool for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The information submission tool, the interRAI - PEDS-HC, and the interRAI - HC are available on request from the department. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

(1) The assessment as listed in paragraph 83.42(1)*"b"* will be completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care.

(2) The department will be responsible for approval of the certification of the level of care, and the department or an MCO will be responsible for annual redeterminations.

(3) AIDS/HIV waiver services will not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income that does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) *Need for services.*

a. The designated case manager will review the assessment of the person's need for waiver services and determine the availability and appropriateness of services. This review will be based, in part, on information in the completed information submission tool designated in paragraph 83.42(1)*"b"* and other supporting documentation as relevant.

b. The total monthly cost of the AIDS/HIV waiver services will not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of $2,026.03.

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.43(2) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program will be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, that is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed assessment has been submitted to the department.

b. Decisions will be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the member service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(3) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—paragraph 75.6(4)*"b"* and rule 441—75.82(249A) do not apply is the date on which income and resource eligibility and level of care determinations are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 120 or more consecutive

days for other than respite care will be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through a notice of decision. If the member returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—paragraph 75.6(4)*"b"* and, for married persons, in rule 441—75.82(249A) have been satisfied is the date on which the income eligibility and level of care determinations are completed but will not be earlier than the first of the month following the date of application.

83.43(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(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 will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) *Maintenance needs of the individual.* The maintenance needs of the individual will be computed by deducting an amount that is 300 percent of the maximum monthly payment for one person under SSI from the client's total income.

83.44(2) *Limitation on payment.* If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services will be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors will be made in accordance with rules 441—76.17(249A) and 441—83.42(249A). A redetermination will include the components listed in rule 441—83.47(249A).

83.45(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.45(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan will be prepared for AIDS/HIV waiver members in accordance with rule 441—130.7(234) except that service plans for both children and adults will be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan will include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan will indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan will identify:

a. The independent support broker selected by the member; and

b. The financial management service selected by the member.

83.47(3) Service plans for members aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan will identify a plan for emergencies and the supports available to the member in an emergency.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services will be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in paragraph 83.42(2)*"b"* or cannot be met by the services provided under the waiver.

d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

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

b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in paragraph 83.42(2)*"b."*

c. The client receives care in a hospital or nursing facility for 120 days or more in any one stay for purposes other than respite care.

d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.48(3) Reduction of services will apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

441—83.49(249A) Appeal rights. Notice of adverse action shall be given in accordance with rule 441—16.2(17A). The right to appeal shall be given in accordance with 441—Chapter 7.

441—83.50 to **83.59** Reserved.

These rules are intended to implement Iowa Code section 249A.4.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

"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 with an intellectual disability aged 18 or over.

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

"Basic individual respite" means respite provided on a staff-to-member 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, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Case management" means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, and community-based case management provided through managed care.

"Case manager" means the staff person providing all categories of case management services regardless of the entity providing the services or the program in which the member is enrolled.

"Child" means a person with an intellectual disability aged 17 or under.

"Client participation" means the posteligibility amount of the member's income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

"Counseling" means face-to-face mental health services provided to the member and caregiver by a QIDP to facilitate home management of the member and prevent institutionalization.

"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.

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

"Guardian" means a guardian appointed in 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 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.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) that will be made only when the onset of the person's condition was during the developmental period and will be based on an assessment of the person's intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the DSM.

"Intermediate care facility for persons with an intellectual disability (ICF/ID)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the DSM or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

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

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

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"MCO"* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"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 a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

"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 an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

"Organization" means the entity being certified.

"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 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.

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

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master's degree in psychology from an accredited school.
7. 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 who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. 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.
9. A professional dietitian who is eligible for registration by the Academy of Nutrition and Dietetics.

10. 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 and psychology.

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

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to 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.
2. It is manifested before the age of 22.
3. It is likely to continue indefinitely.
4. 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.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"SIS assessment" means the Supports Intensity Scale® assessment developed and licensed by the American Association on Intellectual and Developmental Disabilities for use in the assessment of the support and service needs of individuals.

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

"Third-party payment" means payment 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.

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

b. Be eligible for Medicaid under supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage groups; 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.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The department will be responsible for the initial approval, and the department or an MCO will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a member must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

h. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

i. For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

j. Choose HCBS intellectual disability waiver services rather than ICF/ID services.

k. To be eligible for interim medical monitoring and treatment services the member 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 member is eligible must be maximized before the member accesses interim medical monitoring and treatment.);

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

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

l. Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

m. For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the department. Requests for approval shall be submitted in writing to the department and shall include the following:

1. Social history;

2. Case history that includes previous placements and service programs;

3. Medical history that includes major illnesses and current medications;

4. Current psychological evaluations and consultations;

5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;

6. Any current court orders in effect regarding the child;

7. Any legal history;

8. 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;

9. Whether the proposed placement would be safe for the child and for other children living in that setting; and

10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/ID;

2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)*"a"*; or

3. Be a child whose long-term placement outside the home 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, as documented in the service file.

n. For day habilitation, be 16 years of age or older.

o. For the consumer choices option as set forth in 441—subrule 78.41(15), not be living in a residential care facility.

83.61(2) *Need for services.*

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange completion of the information submission tool for children under the age of five and, for all others, a SIS assessment.

b. Applicants not receiving services as set forth in paragraph 83.61(2)*"a"* shall have a department service worker or case manager:

(1) Arrange for completion of the information submission tool for children under the age of five and, for all others, a SIS assessment for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant's needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager will be referred to a Medicaid case manager.

d. Services will not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests will 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 case manager shall coordinate with the department for completion of an information assessment tool for children under the age of five and, for all others, to arrange a SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the case manager can document difficulty in locating information necessary to arrange the assessment or other circumstances beyond the case manager's control.

g. At initial enrollment, the case manager will establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager will complete an annual review thereafter. The following criteria will be used for the initial and ongoing identification of need for services:

(1) The assessment will be based on the results of the most recent information assessment tool for children under the age of five and, for all others, the SIS assessment or the SIS contractor's off-year review.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 16 or under which include supported community living services beyond intermittent will be approved (signed and dated) by the department. The service worker, department QIDP, or Medicaid case manager will 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 will provide a rationale for requesting supported community living beyond intermittent. The rationale will contain sufficient information for the 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 intellectual disability waiver program limit.* The number of persons receiving HCBS intellectual disability waiver services in the state will be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department will make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots will be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

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 will be sent to the person by the department.

83.61(4) *Securing a payment slot.* The department will determine whether a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot will be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department will give written notice to the applicant.

(2) The department will 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 will 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.

b. If no payment slot is available, the applicant will be placed on a statewide priority waiting list. The department will assess each applicant to determine the applicant's priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. 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.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. 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.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion will be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4)*"b"*(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion will be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list will be based on the total number of criteria in subparagraph 83.61(4)*"b"*(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria will be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant will be placed higher on the waiting list.

(6) Applicants will 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 local department office and request that a new assessment be completed. The outcome of the assessment will determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons will be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department will give written notice to the person within five working days.

(2) The department will 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 will 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.

d. The state reserves payment slots each waiver year (July 1 to June 30) for use by children who must reside outside the family home in a residential-based supported community living licensed residential care facility. The state also reserves payment slots each waiver year (July 1 to June 30) for use by members living in an ICF/ID, nursing facility, or out-of-state placement, or transitioning from the Money Follows the Person Grant, who choose to access services in the intellectual disability waiver program and leave the ICF/ID, nursing facility, or out-of-state placement to live in the community.

(1) Applicants who currently reside in an ICF/ID or nursing facility and have resided in that setting for four or more months may request a reserved capacity slot through the intellectual disability waiver.

(2) Applicants will be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(3) In the event that more than one request for a reserved capacity slot is received at one time, applicants will be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(4) Persons who do not fall within the available reserved capacity slots will have the person's name maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons will be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on the person's order on the waiting list.

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) will be followed.

83.62(2) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program will 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 will be made as soon as possible.

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

c. An applicant will be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker will have the member or legal representative indicate the member's choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved will not be reimbursed by the HCBS waiver program.

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

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

83.62(3) *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—paragraph 75.6(4)*"b"* and, for married persons, in rule 441—75.82(249A) have been satisfied.

d. Eligibility continues until the member fails to meet eligibility criteria listed in rule 441—83.61(249A). Members who are inpatients in a medical institution for 120 consecutive days will receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Members will be reviewed for eligibility under other Medicaid coverage groups. The member or legal representative will participate in the review and receive formal notification of that decision through a notice of decision.

If the member returns home before the effective date of the notice of decision and the member'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 service plan staffing meeting and the corresponding long-term care need determination.

83.62(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(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 will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will 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 will be computed by deducting an amount for the maintenance needs of the individual that 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 nonfinancial eligibility for HCBS intellectual disability waiver services will be completed at least once every 12 months. In years in which a SIS assessment is not completed for an individual five years of age or older, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment. An information assessment tool will be completed annually for children under the age of five. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.64(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

441—83.65 Reserved.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

441—83.67(249A) Service plan. A service plan will be prepared for each HCBS intellectual disability waiver member.

83.67(1) *Development.* The service plan will be developed by the interdisciplinary team that includes the member, and, if appropriate, the legal representative, member's family, case manager or service worker, service providers, and others directly involved.

83.67(2) *Retention.* The service plan will be stored by the case manager for a minimum of three years.

83.67(3) *Interdisciplinary team meeting.* The interdisciplinary team meeting will be conducted before the current service plan expires.

83.67(4) *Information in plan.* The plan will be in accordance with 441—subrule 24.4(3) and will additionally include the following information to assist in evaluating the program:

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

b. For supported community living:

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

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

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

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

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The name of the service provider responsible for providing each service.

e. The service funding source.

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

g. Whether the member has elected the consumer choices option and, if so:

(1) The independent support broker selected by the member; and

(2) The financial management service selected by the member.

h. A plan for emergencies and identification of the supports available to the member in an emergency.

i. For members receiving daily supported community living, day habilitation or adult day care: the following standard scores from the most recently completed SIS assessment:

(1) Score on subsection 1A: Exceptional Medical Support Needs.

(2) Score on subsection 1B: Exceptional Behavioral Support Needs.

(3) Sum total of standard scores on the following subsections:

1. Subsection 2A: Home Living Activities;
2. Subsection 2B: Community Living Activities;
3. Subsection 2E: Health and Safety Activities; and
4. Subsection 2F: Social Activities.

83.67(5) *Documentation.* The Medicaid case manager will ensure that the member's case file contains the member's service plan and documentation supporting the diagnosis of intellectual disability.

83.67(6) *Approval of plan.* The plan will be approved through the institutional and waiver authorization and narrative system (IoWANS). Services shall be entered into IoWANS based on the service plan.

a. Services must be authorized and entered into IoWANS before the plan implementation date.

b. The department 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 unless the parties mutually agree to extend that time frame.

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

441—83.68(249A) Adverse service actions.

83.68(1) *Denial.* An application for services will 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. No HCBS intellectual disability waiver service is identified in the applicant's service plan.

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—paragraph 130.5(3)*"a"* or *"b"* apply.

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

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

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

c. No HCBS intellectual disability waiver service is identified in the member'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 department for the HCBS program member has not occurred.

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

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

441—83.69(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal shall be given in accordance with 441—Chapter 7.

441—83.70(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. More information can be found in 265—Chapter 24.

441—83.71 to **83.80** Reserved.

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

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 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.

"Basic individual respite" means respite provided on a staff-to-member 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, that 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.
Cerebral edema.
Cerebral palsy.
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.
Status epilepticus.

"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 member'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.

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

"Guardian" means a guardian appointed in 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 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.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the DSM or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"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.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"MCO"* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"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 a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

"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.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.
2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Organization" means the entity being certified.

"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 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.

"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; psychiatrist; physician; physician assistant; registered nurse; certified teacher; licensed clinical social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in human services, social work, psychology, sociology, or public health or rehabilitation services plus 4,000 hours of direct experience with people living with a brain injury.

"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 person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

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

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

"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.

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a member 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 supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.

c. Be at least one month of age.

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

e. Reserved.

f. Be determined by the department as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed information submission tool for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over, the most recent version of the Mayo-Portland Adaptability Inventory (MPAI), and other supporting documentation as relevant. The information submission tool, the interRAI - PEDS-HC, and the interRAI - HC and the MPAI are available on request from the member's MCO or the department. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

g. Be assessed by the department 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 in addition to case management.

i. Choose HCBS.

j. To be eligible for interim medical monitoring and treatment services the member 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 member is eligible must be maximized before the member accesses interim medical monitoring and treatment.);

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

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

k. Receive services in a community, not an institutional, setting.

l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.

m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

n. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in this outcome.

o. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

p. For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in community employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive prevocational services was made.

83.82(2) *Need for services.*

a. The applicant will have a service plan approved by the department that is developed by the Medicaid case manager for this waiver. This must be completed before services provision and annually thereafter. The case manager will establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant'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 department.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state plan services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 16 or under that include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the department. 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 service plan. The rationale must contain sufficient information for the department's designee 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 will 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 member shall access, if a child, all other services for which the person is eligible and that are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

83.82(3) *Securing a state payment slot.*

a. The department field office will enter all waiver applications into the institutional and waiver authorization and narrative system (IoWANS) to determine whether a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the department field office will make the entry by the end of the fifth working day after receipt of a completed services application or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the department field office will make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department will enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid will be entered on the waiting list on the basis of the date a completed health services application is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid will be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants will be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

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

d. Applicants who currently reside in a community-based neurobehavioral rehabilitation residential setting, an ICF/ID, a skilled nursing facility, or an ICF and have resided in that setting for four or more months may request a reserved capacity slot through the brain injury waiver.

(1) Applicants will be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(2) In the event that more than one request for a reserved capacity slot is received at one time, applicants will be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(3) Persons who do not fall within the available reserved capacity slots will have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons will be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

e. The department will reserve a set number of funding slots each waiver year for emergency need for all applicants who are on the waiting list maintained by the state. Applicants may request an emergency need reserved capacity slot by submitting the completed home- and community-based services (HCBS) brain injury waiver emergency need assessment to the department.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter, and no alternative housing options are available.

4. 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.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. 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.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion will be placed on the emergency reserved capacity priority waiting list based on the total number of criteria in subparagraph 83.82(3)*"e"*(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion will be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list will be based on the total number of criteria in subparagraph 83.82(3)*"e"*(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria will remain on the waiting list, based on the date of application. If the application date is the same, the older applicant will be placed higher on the waiting list.

(6) Applicants will 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 and request that a new emergency needs assessment be completed. The outcome of the assessment will determine placement on the waiting list as directed in this subrule.

f. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department will give written notice to the person within five working days.

(2) The department will 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 will 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.

441—83.83(249A) Application.

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

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

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

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

c. An applicant will be given the choice between waiver services and institutional care. The applicant or legal representative will sign the applicable information submission tool listed in paragraph 83.82(1)*"f,"* indicating that the applicant has elected home- and community-based services. This will be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, will contact the member's MCO or the designated case manager to initiate development of the member's service plan 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 will establish an HCBS BI waiver interdisciplinary team for each member and, with the team, identify the member's "need for service" based on the member'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—paragraph 75.6(4)*"b"* and, for married persons, in rule 441—75.82(249A) have been satisfied.

c. Eligibility for the waiver continues until the member fails to meet eligibility criteria listed in rule 441—83.82(249A). Members who return to inpatient status in a medical institution for more than 120 consecutive days will be reviewed by the department to determine additional inpatient needs for possible termination from the brain injury waiver. The member will be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.17(249A). The member will be notified of that decision through a notice of decision.

If the member returns home before the effective date of the notice of decision and the member'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—75.82(249A), the date on which the waiver member meets the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

441—83.84(249A) Client participation. Members who are financially eligible under 441—paragraph 75.6(4)*"b"* (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 will be computed by deducting an amount for the maintenance needs of the member that is 300 percent of the maximum SSI grant for an individual from the member'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 will make no payments for the waiver service. However, Medicaid will make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver will be completed at least once every 12 months. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination will 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, adult day care, member-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) Service plan. A service plan will be prepared and utilized for each HCBS BI waiver member. The service plan will be developed by an interdisciplinary team that includes the member, and, if appropriate, the legal representative, member's family, case manager, providers, and others directly involved. The service plan will be stored by the case manager for a minimum of three years. The service plan staffing will be conducted before the current service plan expires.

83.87(1) *Information in plan.* The plan will be in accordance with 441—subrule 24.4(3) and will additionally include the following information to assist in evaluating the program:

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

b. For supported community living:

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

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

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

c. An identification and justification of any restriction of a member'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 member.

g. Whether the member has elected the member choices option and, if so:

(1) The independent support broker selected by the member; and

(2) The financial management service selected by the member.

h. A plan for emergencies and identification of the supports available to the member in an emergency.

83.87(2) *Use of nonwaiver services.* Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 16 or under that include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the department. The Medicaid case manager will attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) *Annual assessment.* The department will assess the member annually and certify the member's need for long-term care services. The department will be responsible for determining the level of care based on the completed information submission tool listed in paragraph 83.82(1)*"f"* and other supporting documentation as relevant.

a. The department or the member's MCO will be responsible for annual redetermination of the level of care.

b. The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.87(4) *Service file.* The Medicaid case manager must ensure that the member service file contains the member's service plan.

441—83.88(249A) Adverse service actions.

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

a. The member 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 member's service plan.

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

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

h. The member 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—paragraph 130.5(3)*"a"* or *"b"* apply.

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

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

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

c. The brain injury waiver service is not identified in the member'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 department or the medical facility discharge planner for the brain injury waiver service member has not occurred.

g. The member receives services from other Medicaid providers.

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

441—83.89(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 7.

441—83.90 to **83.100** Reserved.

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

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 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.

"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 member'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.

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

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the DSM or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"MCO"* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.
2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"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 person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Third-party payment" means payment from an individual, institution, corporation, or public or private provider that is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a member 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 member 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 department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act as amended to July 1, 2026, or the disability guidelines for the Medicaid employed people with disabilities coverage group.

c. Be ineligible for the HCBS intellectual disability 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 parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the member.

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

f. Be aged 18 years to 64 years.

g. Reserved.

h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on a completed interRAI - Pediatric Home Care (PEDS-HC) for those aged 18 to 20 or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The interRAI - PEDS-HC and the interRAI - HC are available on request from the department. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

(1) Initial decisions on level of care will be made for the department by the department within two working days of receipt of medical information. Iowa Medicaid 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).

(2) Adverse decisions may be appealed to the department pursuant to 441—Chapter 7.

i. Choose HCBS.

j. Use a minimum of one unit of service per calendar quarter under this program.

k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) *Need for services.*

a. The applicant will have a service plan that is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The designated case manager will identify the need for service based on the needs of the applicant, as documented in the information submission tool listed in paragraph 83.102(1)*"h,"* as well as the availability and appropriateness of services.

(2) The service worker will have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, will not exceed $761.95 per month.

83.102(3) *Slots.* The total number of persons receiving HCBS physical disability waiver services in the state will be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots will be available on a first-come, first-served basis.

83.102(4) *Securing a slot.*

a. The department field office will enter all waiver applications into the institutional and waiver authorization and narrative system (IoWANS) to determine whether a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the department field office will make the entry by the end of the fifth working day after receipt of a completed application for health services and help paying costs or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the department field office will make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department will enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid will be entered on the basis of the date a completed health services application is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid will be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants will 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 will 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 will have their applications rejected but their names will be maintained on the waiting list. As slots become available, persons will be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(5) *HCBS physical disability waiver waiting list.* When services are denied because the limit on the number of slots 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 will 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) through 441—76.6(249A) will be followed.

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

a. Applications for this waiver will 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.

(1) The discharge planner will contact the member's MCO or designated case manager to arrange for completion of the appropriate information submission tool as listed in paragraph 83.102(1)*"h."*

(2) After completing the determination of the level of care needed by the applicant, the department will inform the income maintenance worker and the discharge planner of the decision.

b. Applications for this waiver will be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's MCO or the designated case manager will arrange for the completion of the appropriate information submission tool as listed in paragraph 83.102(1)*"h"* and submit it to the department.

(2) After completing the determination of the level of care needed by the applicant, the department will inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver will 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 will be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant will be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care will sign the information submission tool, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care will cooperate with the designated case manager in the development of the service plan 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 member 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 subrule 83.102(1).

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 subrule 83.102(1) and when the eligibility factors set forth in 441—paragraph 75.6(4)*"b"* and, for married persons, in rule 441—75.82(249A) have been satisfied.

c. Eligibility for the waiver continues until the member fails to meet eligibility criteria listed in subrule 83.102(1). Members who return to inpatient status in a medical institution for more than 120 consecutive days will be reviewed by Iowa Medicaid to determine additional inpatient needs for possible termination from the physical disability waiver. The member will be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.17(249A). The member will be notified of that decision through a notice of decision.

If the member returns home before the effective date of the notice of decision and the member'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—75.82(249A), the date on which the waiver member meets the institutional level of care requirement as determined by the department or an appeal decision will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for a prior institutionalization will be applied to the waiver application.

441—83.104(249A) Client participation. Members who are financially eligible under 441—paragraph 75.6(4)*"b"* (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 will be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum supplemental security income (SSI) grant for an individual from the member'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 will make no payments for the waiver service. However, Medicaid will make payments to other medical providers.

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver will be completed at least once every 12 months. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination will 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 member-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

441—83.107(249A) Individual service plan. An individualized service plan will be prepared and used for each HCBS physical disability waiver member. The service plan will be developed and approved by the member, the member's interdisciplinary team and the designated case manager prior to services beginning and payment being made to the provider.

83.107(1) *Information in plan.* The plan will be in accordance with 441—subrule 24.4(3) and will additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a member 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 member.

e. Whether the member has elected the member choices option and, if so:

(1) The independent support broker selected by the member; and

(2) The financial management service selected by the member.

f. A plan for emergencies and identification of the supports available to the member in an emergency.

83.107(2) *Annual assessment.* The department or an MCO will review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1)*"h"* and the appeal process in rule 441—83.109(249A), based on the appropriate information submission tool as listed in paragraph 83.102(1)*"h"* and other supporting documentation as relevant.

a. The department or the member's MCO will be responsible for annual redetermination of the level of care.

b. The MCO must submit documentation to Iowa Medicaid for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

441—83.108(249A) Adverse service actions.

83.108(1) *Denial.* An application for services will 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 member's service plan.

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

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

h. The member 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—paragraph 130.5(3)*"a"* or *"b"* apply.

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

a. The provisions of 441—paragraph 130.5(2)*"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 member'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 member for the physical disability waiver service has not occurred.

g. The member receives services from other Medicaid providers.

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

441—83.109(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 7.

441—83.110 to **83.120** Reserved.

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

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

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

"Case manager" means the person designated to provide Medicaid targeted case management services for the member.

"CMS" means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

"Deeming" means considering parental or spousal income or resources as income or resources of a member in determining eligibility for a member according to Supplemental Security Income program guidelines.

"Guardian" means a parent of a member or a legal guardian appointed by the court.

"HCBS" means home- and community-based services provided under a Medicaid waiver.

"IME QIO" means the entity contracted with the department that determines the level of care for members initially applying for or continuing to receive children's mental health waiver services.

"Interdisciplinary team" means the member, the member's family, and persons of varied professional and nonprofessional backgrounds with knowledge of the member's needs, as designated by the member and the member's family, who meet to develop a service plan based on the individualized needs of the member.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"MCO"* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Medical institution" means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

"Member" means an individual up to the age of 18 who is included in a Medicaid coverage group listed in rule 441—75.1(249A) and is a recipient of children's mental health waiver services.

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

1. 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 osteopathic medicine; and
2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and
3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Psychiatric medical institution for children level of care" means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.10(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the DSM and (2) has resulted in a functional impairment that substantially interferes with or limits a member's role or functioning in family, school, or community activities. "Serious emotional disturbance" does not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as "other conditions that may be a focus of clinical attention," unless these conditions co-occur with another diagnosable serious emotional disturbance.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team that includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Targeted case management" means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for members eligible for the children's mental health waiver.

"Waiver year" for the children's mental health waiver means a 12-month period commencing on July 1 of each year.

441—83.122(249A) Eligibility. To be eligible for children's mental health waiver services, a member must meet all of the following requirements:

83.122(1) *Age.* The member must be under 18 years of age.

83.122(2) *Diagnosis.* The member must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children's mental health 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.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) *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 department or an MCO will certify the applicant's level of care annually based on information submitted on a case management comprehensive assessment for children aged 3 and under or on the interRAI - child and youth mental health (ChYMH) for those aged 4 to 20 and other supporting documentation as relevant. For those aged 12 to 18, the interRAI - adolescent supplement will also be completed in addition to the interRAI - ChYMH. The interRAI - ChYMH and the interRAI - adolescent supplement are available on request from the department. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

83.122(4) *Financial eligibility.* The member must be eligible for Medicaid as follows:

a. Be eligible for Medicaid under a supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage group; or

b. Be eligible under the special income level (300 percent) coverage group; or

c. Become eligible through application of the institutional deeming rules; or

d. 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.

83.122(5) *Choice of program.* 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 the assessment.

83.122(6) *Need for service.* The member must have service needs that can be met under the children's mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.127(249A).

a. The member must be a recipient of case management or be identified to receive case management immediately following program enrollment.

b. The total cost of children's mental health waiver services needed to meet the member's needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed $2,165.87 per month.

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

d. A member may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

e. A member may be enrolled in only one HCBS waiver program at a time.

441—83.123(249A) Application. The Medicaid application process as specified in rules 441—76.1(249A) through 441—76.6(249A) will be followed for an application for HCBS children's mental health waiver services.

83.123(1) *Program limit.* The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of members specified in the approved waiver, the member's application will be rejected and the member's name shall be placed on a waiting list.

a. The local office will determine whether a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed application for health services or help paying costs from a member who is not currently a Medicaid member; or

(2) A written request signed and dated by a Medicaid member's parent or legal guardian.

b. When a payment slot is available, the local office will enter the application into institutional and waiver authorization and narrative system (IoWANS) to begin the waiver approval process.

(1) The department will hold the payment slot for the member as long as reasonable efforts are being made to arrange services and the member has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot will revert for use by the next member on the waiting list, if applicable. The member must reapply for a new slot.

c. If no payment slot is available, the department will enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed application for health services or help paying costs is received by the department;

(2) The names of Medicaid members will be added to the waiting list on the date as specified in paragraph 83.123(1)*"a."*

(3) In the event that more than one application is received at one time, the names of members will be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Members whose names are on the waiting list will be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved members on the program is maintained.

(1) Once a payment slot is assigned, the department will give written notice to the member within five working days.

(2) The department will hold the payment slot for 30 days for the member to file a new application.

(3) If an application has not been filed within 30 days, the slot will revert for use by the next member on the waiting list, if applicable. The member originally assigned the slot must reapply for a new slot.

e. The state reserves payment slots each waiver year (October 1 to September 30) for use by members living in a state of Iowa mental health institute (MHI), a psychiatric residential treatment facility (PRTF), or an out-of-state facility placement who choose to access services in the children's mental health waiver program and leave the MHI, PRTF, or out-of-state placement to live within their family home. For the purpose of reserved capacity within the children's mental health waiver program, an MHI is defined in Iowa Code section 226.1 and a PRTF is defined in 42 CFR 483.352.

(1) Applicants who currently reside in an MHI, PRTF, or out-of-state placement and have resided in that setting for four or more months may request a reserved capacity slot through the children's mental health waiver program.

(2) Applicants will be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(3) In the event that more than one request for a reserved capacity slot is received at one time, applicants will be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(4) Persons who do not fall within the available reserved capacity slots will have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons will be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

83.123(2) *Approval of waiver eligibility.*

a. Time limit. Applications for the HCBS children's mental health waiver program will be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal SSI benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the member or the department.

(3) The application is pending because the assessment has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a completed assessment, the application will be denied.

b. Notice of decisions. The department will mail or give decisions to the applicant on the dates when eligibility and level of care determinations are completed.

83.123(3) *Effective date of eligibility.* The effective date of a member's eligibility for children's mental health waiver services will be the first date that all of the following conditions exist:

a. All eligibility requirements are met; and

b. Eligibility and level of care determinations have been made.

441—83.124(249A) Financial participation. A member must contribute to the cost of children's mental health waiver services to the extent of the member's total income less 300 percent of the maximum monthly payment for one person under the federal SSI program.

441—83.125(249A) Redetermination. The department will redetermine a member's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the member's situation or condition.

83.125(1) *Eligibility review.*

a. Every 12 months, the department will review a member's eligibility in accordance with procedures in rule 441—76.17(249A). The review will verify continuing eligibility factors as specified in rule 441—83.122(249A).

b. The department or an MCO will review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process in rule 441—83.129(249A), based on the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

c. The department or the member's MCO will be responsible for annual redetermination of the level of care.

d. The MCO must submit documentation to Iowa Medicaid for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.125(2) *Continuation of eligibility.* A member's waiver eligibility will continue until one of the following conditions occurs.

a. The member fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The member is an inpatient of a medical institution for 120 or more consecutive days.

(1) After the member has spent 120 consecutive days in a medical institution, the local office will terminate the member's waiver eligibility and review the member for eligibility under other Medicaid coverage groups. The local office will notify the member and the member's parents or legal guardian through a notice of decision.

(2) If the member returns home after 120 consecutive days, the member must reapply for children's mental health waiver services, and Iowa Medicaid must redetermine the member's level of care.

c. The member does not reside at the member's natural home for a period of 60 consecutive days. After the member has resided outside the home for 60 consecutive days, the local office will terminate the member's waiver eligibility and review the member for eligibility under other Medicaid coverage groups. The local office will notify the member and the member's parents or legal guardian through a notice of decision.

83.125(3) *Payment slot.* When a member loses waiver eligibility, the member's assigned payment slot will revert for use to the next member on the waiting list.

441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver will be provided as set forth in rule 441—78.52(249A) and will include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

441—83.127(249A) Service plan. The member's case manager will prepare an individualized service plan for each member that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan will be developed through an interdisciplinary team process.

83.127(2) The service plan will be developed annually or when there is significant change in the member's situation or condition.

83.127(3) The service plan will be based on information in the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

83.127(4) The service plan will specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan will identify and justify any restriction of the member's rights.

441—83.128(249A) Adverse service actions.

83.128(1) *Denial.* An application for children's mental health waiver services will be denied when the department determines that:

a. The member is not eligible for or in need of waiver services.

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

c. Service needs exceed the limit on aggregate monthly costs established in paragraph 83.122(6)*"b"* or are not met by the services provided.

83.128(2) *Termination.* A member's participation in the children's mental health waiver program may be terminated when the department determines that:

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

b. The costs of the children's mental health waiver services for the member exceed the aggregate monthly costs established in paragraph 83.122(6)*"b."*

c. The member receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 120 days in any one stay.

d. 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 member's case manager.

e. Service providers are not available.

83.128(3) *Reduction.* Reduction of services will apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

441—83.129(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 7.

These rules are intended to implement Iowa Code section 249A.4 and chapter 249J.