

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.

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