

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 441—subrule 78.34(13), 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.

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