Section 8:

On the Waiver

Congratulations on making it onto the waiver. To move forward with the waiver, you will be asked to complete several steps to begin or maintain waiver funding. Below you will find a breakdown of assessments, annuals, and contact requirements for waiver funding. In addition, you will find a brief breakdown of unit requirements for waiver services. For services on the waiver please see the previous section titled Medicaid Eligible Services.

Assessments:

Each year you will be asked to participate in an annual assessment, also known as a Level of Care (LOC). These assessments go by several names and will vary based on the waiver you are on and the age of the individual receiving services. The Assessments are facilitated by a Core Standardized Assessment (CSA) Assessor from Amerigroup, Iowa Total Care, or Telligen. It is extremely important for you to complete the assessments in the time requested to ensure you do not have a gap in services. If assessments are not completed in a timely manner, you will lose access to waiver services until the assessment is completed. After an extended period of time, you may be removed from waiver services and will have to reapply for waiver services, which includes time on the waitlist. On the next page you will find a chart specifying what assessment will be administered based on an individual's waiver:

HCBS Waiver Level of Care Assessment Tools	AGE	AIDS/ HIV	BI	HD	PD	Elderly (EW)	CMH	ID
Case Manager Comprehensive Assessment (or modified PIHH for CMH)	0 - 3	X	X	X			X	
	0 - 4							X
interRAI - Pediatric Home Care (PEDS - HC)	4 - 20	X	X	X				
	18 - 19							
	18 - 20				X			
interRAI - Home Care (HC)	21+	X	X		X			
	21 - 64			X				
	65+					X		
interRAI - Child and Youth Mental Health (ChYMH)	4 - 20					X		
	16 - 18							
interRAI - Child and Youth Mental Health (ChYMH) and Adolescent Supplement	12 - 18						X	
Supports Intensity Scale Child (SIS-C)	5 - 15							X
Supports Intensity Scale Adult (SIS-A)	16+							X

HCBS Habilitation	HCBS Habilitation and HCBS Waiver (when a member is requesting to participate or is participating in the HCBS Habilitation program and a HCBS Waiver program).								
	AGE	HAB	AIDS/ HIV HAB	BI HAB	HD HAB	PD HAB	EW HAB	ID HAB	CMH HAB
Child and Adolescent Level of Care Utilization System (CALOCUS)	4-18	X	X	X	X	X			
Level of Care Utilization System (LOCUS)	19 +	X	X	X	X	X	X	X	X
Supports Intensity Scale Adult (SIS-A)	16+							X	

Human Services Department (441) ARC 3184C https://rules.iowa.gov/Notice/Details/3184C.

Case Manager Comprehensive Assessment & Social History

Case Manager Comprehensive Assessment & Social History is a fact-finding tool to gather all necessary and pertinent information about the individual receiving services. This tool is used to develop the individuals Person-Centered Service Plan (PCSP). Assessment information includes personal information, communication and language, leisure activities, marital and dating status, developmental milestones, medical and mental health history, behavioral and mental health, hospitalization and emergency room visit history, preventative visits, allergies, physical health, domestic violence, physical, emotional, sexual abuse and trauma, medications, medical support team, substance use or abuse, self-care, ADL's, IDL's, transportation, employment and volunteering, education history, housing, finances, legal information, future identified goals and needs, and identified risks and needs completed through the assessment documentation. Prior to your meeting with the case manager, it will be helpful to have all the information and necessary dates available for the meeting. Beginning July 1, Case Manager Comprehensive Assessments and Social History will be done on all Habilitation and Children Mental Health individuals.

interRAI

interRAI is a clinical assessment instrument completed by a trained Core Standardized Assessment (CSA) Assessor once per year focusing on a person-centered approach to services needed. The screening tool is used to collect information on the individual's specific needs focusing on identifying key factors including clinical and social support, service use, cognitive and mental health, daily activities, and self-care. The assessment results will help in the development of the individuals care plan. The average interRAI takes 1 to 2 hours to complete.

To complete a successful assessment, two reliable respondents are required and can include the diagnosed individual who is able to provide reliable answers, an individual who has known the person being evaluated for at least three months, and an individual who has recently observed the person in one or more environments for substantial period of time (i.e., case manager, parent/guardian, staff, job-coach, teacher, etc.).

For more information on interRAI visit: https://interrai.org.

Level of Care Utilization System (LOCUS)
Child and Adolescent Level of Care Utilization System (CALOCUS)

Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) have replaced interRAI assessments for individuals on the Habilitation and Children's Mental Health Waivers beginning July 1st, 2022. The assessment tool was developed by the

American Association of Community Psychiatrist (AACP) and is completed by a trained Special Habilitation Assessor once per year. The assessment focusing on a current person-centered approach to ensure services are used efficiently and effectively. The Assessor will address six key domains: risk of harm, functional status, medical – addictive and psychiatric co-morbidity, recovery environment, treatment and recovery history, and engagement and recovery status. In conjunction with four service continuum variables; care environment, clinical services, support services, and crisis resolution and prevention services. These parameters identify an individual's specific needs through a scoring system to determine qualifications and requirements for intensive residential habilitation services (IRHS), determines the level of home-based habilitation service authorization, intensive residential habilitation service and service criteria, options for residential services to minors residing outside of their family home, and the continued need for services.

A LOCUS or CALOCUS scoring is completed by the Accessor based on information in the Case Manager Comprehensive Assessment, Social History, and other records pertinent to the individual (i.e., medical records). An individual will still complete the other assessments necessary for their waiver but will not have a set meeting for the LOCUS or CALOCUS.

For more information on LOCUS visit: https://dhs.iowa.gov/sites/default/files/LOCUS_Levels_Care_Handout.pdf?062820221756.

For more information on CALOCUS visit: https://dhs.iowa.gov/sites/default/files/CALOCUS_Levels_of_Care_Handout.pdf?062820221748.

Mayo-Portland Adaptability Inventory

The Mayo-Portland Adaptability Inventory or Mayo-Portland for short is administered in partnership with the appropriate interRAI. The Mayo Portland focuses on three subscales of ability index, adjustment index, participant index. Currently in its 4th edition, the MPAI-4. The assessment works as an evaluation for individuals diagnosed with a brain injury. Questions in the assessment are ranked utilizing a 5-point Likert scale to rank cognitive, behavioral, emotional, physical, and social problems the individual experiences due to their brain injury. The scale is ranked from 0 to 4 with 0 meaning no functional disabilities for the domain question are indicated and 4 meaning the impairment interferes most of the time for the individual. For those on the Brain Injury Waiver, you should allow 2 to 3 hours of time to complete the interRAI and Mayo-Portland Adaptability Inventory during your yearly assessment meeting.

To complete a successful assessment, two reliable respondents are required and can include the diagnosed individual who is able to provide reliable answers, an individual who has known the person being evaluated for at least three months, and an individual who has recently observed the

person in one or more environments for a substantial period of time (i.e., case manager, parent/guardian, staff, job-coach, teacher, etc.).

For more information on Mayo-Portland Adaptability Inventory visit: https://www.youtube.com/watch?v=URugJrxVDrw.

Off-Year Assessments (OYA)

For those on the ID Waiver, not all individuals will need to participate in a yearly Supports Intensity Scale (SIS) assessment. For the years you are not asked to participate in a SIS, you will have what is referred to as an Off-Year Assessment (OYA). The OYA is a telephonic review conducted by a Core Standardized Assessment (CSA) Assessor. The shortened assessment allows for the level of care to be determined by the responses to questions related to the individuals medical and behavioral diagnoses, medical conditions, functional ability, and risk factors.

Assessors for Amerigroup, Iowa Total Care or Telligen typically complete the OYA with the case manager. To complete a successful assessment, one reliable respondent is required and can include the diagnosed individual who is able to provide reliable answers, an individual who has known the person well, or an individual who has recently observed the person in one or more environments for a length of time (i.e., parent, guardian, staff, job coach, teacher, etc.). Amerigroup will complete the OYA with the guardian or an individual who is deemed to know the individual well.

The Assessor will complete the OYA with the case manager. For Amerigroup, the OYA can be completed with the guardian or someone who knows the member (i.e., provider, staff, etc.). Only one respondent is needed to complete the OYA.

For more information on Off-Year Assessments visit: https://dhs.iowa.gov/sites/default/files/470-5276.pdf?050420221446 or https://dhs.iowa.gov/sites/default/files/1420%20Intellectual_Disability_Waiver_Off-Year_Assessments-final%20version%20for%20LH%20(2)%20(2).pdf?050420221447.

Supports Intensity Scale (SIS), Supports Intensity Scale Adult Versions (SIS-A), Supports Intensity Scale Children's Version (SIS-C)

SIS is a Core Standardized Assessment (CSA) completed by a trained Assessor every 3 years focusing on the strengths of an individual with an intellectual or developmental disability. The SIS assessment focuses on 84 different categories of needed supports. The goal of the SIS is to focus on an individual's strengths and not their opportunities. The results will help to gauge future planning, support and services for the individual. SIS-A

measures supports for individuals 16 years and older. SIS-C measures supports for individuals 5 to 16 years.

To complete a successful assessment, two reliable respondents are required and can include the diagnosed individual who is able to provide reliable answers, an individual who has known the person being evaluated for at least three months, and an individual who has recently observed the person in one or more environments for substantial period of time (i.e., case manager, parent/guardian, staff, job-coach, teacher, etc.).

For more information on Supports Intensity Scale visit: https://www.aaidd.org/sis.

Intake or Annual Person-Centered Services Planning Process (PCSP)

Each year after your LOC/assessment is completed you will be asked to meet with your Interdisciplinary Team (IDT) to review the individual's care plan for case management and all providers. Your IDT team will include the individual receiving services, guardians, case manager, providers, and any additional team members you wish to have present (i.e., some families wish to have their individual staff or teacher present during the meetings. It is not necessary for them to be in attendance, but they are welcome to attend). The meeting will focus on goals for the coming year, changes to service plans, resolving conflicts from the previous year, education on additional services offered, etc. If this is your first time having a PCSP, it may be referred to as an "Intake Meeting". These meetings can last from 1 to 2 hours based on the number of services you receive and providers you have.

Contact Requirements for Providers

To maintain waiver services your provider must have a minimum of one contact per quarter with the individual or their guardian by phone or face-to-face (i.e., a total of 4 per year and can include assessments, PCSP, quarterly contacts, or IEP meetings).

Contact Requirements for Case Management

To maintain waiver services your case manager must have a minimum of one face-to-face meetings with the individual receiving services in their residence at least one time per quarter (i.e., a total of 4 face-to-face visits per year in the individual's home). In addition, the case manager should have a minimum of one contact per month with the individual, their guardian or representative by phone or face-to-face. The quarterly

in home visit counts as a contact for a monthly contact. At the end of the year, you will have a total of 12 contacts with your case manager.

Unit Breakdown

Once an individual has been placed on waiver funding, they will begin receiving a unit allotment for services that can be provided in the home, community, or at a provider's building. Unit allotments will vary based on their waiver and Level of Care (LOC) results. Some waivers and certain services provide a yearly allotment of units, while others provide a monthly allotment of units. Your case manager will provide you with unit allotments and will discuss them at your PCSP meeting. Units go by a set measure of time (1 unit = 15 minutes). To utilize one hour of service, an individual would need four units (4 units = 60 minutes).

The below equation can be utilized to calculate the number of hours you have available in an allotted time frame:

- Total units/4 units =
  allotment of time in hours available to the individual.

Example 1:

An individual named Joe is on the Health & Disability (HD) Waiver and receives respite services. On the HD Waiver, respite allotments are given at a monthly unit amount. Joe has 40 units of respite available to him monthly.

To calculate the total hour allotment Joe has access to for respite services utilize the below equation:

- Total units/4 units =
  allotment of time in hours available to the individual.
- 40 total units/4 units =
  10 hours a month of respite services Joe is authorized to use.

Example 2:

An individual named Susie is on the Intellectual Disability (ID) Waiver and receives respite and SCL services. On the ID Waiver, respite allotments are given at a plan year unit amount and SCL allotments are given at a monthly unit amount. Susie has 600 units of respite available to her yearly and 30 units of SCL available to her monthly.

To calculate the total hour allotment Susie has access to for respite services utilize the below equation:

- Total units/4 units =
  allotment of time in hours available to the individual.
- 600 units/ 4 units =
  150 hours a plan year of respite services Susie is authorized to use.

To calculate the total hour allotment Susie has access to for SCL services utilize the below equation:

- Total units/4 units =
  allotment of time in hours available to the individual.
- 30 units/4 units =
  7.5 hours a month of SCL services Susie it authorized to use.

Unit Requirements

To maintain services, an individual on a waiver is required to utilize 1 hour of service for every calendar quarter.

Example:

January, February, March = 1 hour/4 units of service required.

April, May, June = 1 hour/4 units of service required.

July, August, September = 1 hour/4 units of service required.

October, November, December = 1 hour/4 units of service required.