



Independent Living Waiver (ILW) is a program available to participants receiving Consumer Directed Services (CDS), with a need for additional assistance to remain in the least restrictive environment. The ILW offers several services, including additional CDS Personal Care, Case Management (CM), Environmental Accessibility Adaptations (EAA), Specialized Medical Equipment (SME), Specialized Medical Supplies (SMS), and Financial Management Services (FMS).

All ILW participants must meet the following eligibility criteria:

- Initial entry into the ILW is limited to individuals 18 years of age to 64 years of age;
 - Individuals who are enrolled in the ILW when they turn sixty-five (65) may remain enrolled in the ILW for as long as they maintain the ability and the desire to self-direct their personal care attendant services.
- Be physically disabled, as defined by 19 CSR 15-8:
- Loss of, or loss of use of, all or part of the neurological, muscular or skeletal functions of the body to the extent that the person requires the assistance of another person to accomplish routine tasks.
- Individuals with a cognitive impairment must have had onset of the cognitive impairment on or after age twenty-two (22);
- Be able to self-direct their own CDS ([Policy 3.25](#));
- Be in active Medicaid status ([Policy 2.00](#));
 - Participants eligible for Medicaid on a spenddown basis may be authorized to receive ILW during periods when spenddown liability is met.
 - o When the participant has **not** met their monthly spenddown liability amount, the participant and provider may make a private arrangement for the continued delivery of services. In these instances, the participant is responsible for the cost of services received.
 - Participants who receive Medicaid due to eligibility for Blind Pension (BP) ([Policy 2.00, Appendix 3](#)) are **not** eligible and shall not be authorized for ILW.
 - Participants in a 'Transfer of Property' penalty period may be authorized for ILW.
 - Authorization of ILW does **not** meet the requirements for an individual to be eligible for Home and Community Based (HCB) Medicaid.
- Have an appropriate Medicaid Eligibility (ME) code ([Policy 2.00, Appendix 3](#));
- Meet nursing facility level of care; and
- Must not be enrolled in any other waiver program, regardless of which state agency administers

the waiver.

Additional restrictions include:

- Individuals who reside in a Skilled Nursing Facility (SNF), Residential Care Facility (RCF), or Assisted Living Facility (ALF) licensed by Department of Health and Senior Services (DHSS), Division of Regulation and Licensure (DRL) are **not** eligible for ILW services;
- Participants authorized for certain services through the Department of Mental Health (DMH) may not be eligible for services as outlined in this policy. Staff shall review Service Coordination guidelines ([Policy 4.35.1](#)) to ensure appropriate service authorization for participants receiving DMH services.
- Participants checked 'CDS Restricted' in the HCBS Web Tool **shall not** be authorized for ILW services ([Policy 10.05](#)).

ILW SERVICES AVAILABLE

Each ILW service has specific criteria for eligibility, including but not limited to:

- Consumer Directed Services, Personal Care (CDS) provides additional CDS when approved State Plan limits are exhausted (see [Policy 3.25](#)).
 - When the participant needs CDS above the State Plan cost maximum, the participant may be considered for ILW enrollment. The scope and nature of CDS does not differ between the ILW or State Plan CDS programs ([Policy 3.25](#)), except for the ability of the participant to designate another individual to direct their care.
 - Any participant who opts to delegate self-direction responsibilities (while still possessing the ability to self-direct) shall have all CDS authorized through the ILW. Participants who choose to delegate self-direction cannot be authorized through State Plan CDS.
 - A physically disabled participant with a *cognitive* impairment that does not affect their ability to self-direct is authorized through the ILW only. Participants who choose to delegate self-direction cannot be authorized through State Plan CDS.
- Financial Management Services (FMS) is provided to participants who receive CDS through the ILW to facilitate employment of attendants by the participant and assist with access to other ILW services, when needed. FMS providers perform the following functions:
 - Assist participant in verifying the attendant's citizenship status;
 - Collect and process Electronic Visit Verification (EVV) records of attendants;
 - Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance;
 - Ensure all funds paid for attendants are used to pay the attendant's wages and all employment related taxes and insurance;
 - Ensure attendant is registered with the Family Care Safety Registry (FCSR);
 - Provide information and assistance to the participant or designee in arranging for, directing,

- and managing services;
- Assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
 - Offer practical skills training to enable families and participants to independently direct and manage waiver services, including;
 - Providing information on recruiting, hiring, and managing attendants;
 - Providing information on effective communication and problem-solving; and
 - Providing information to ensure that participants understand the responsibilities involved with directing their services.
 - Assist in the acquisition of necessary assistive technology services and/or devices such as:
 - Advocating for the participant by arranging for services with individuals, businesses, and agencies for the best available service within existing resources.
 - Assist participant in obtaining three (3) cost statements for the authorization of SME, SMS, and EAA, including:
 - Assuring the purchase price includes the cost of training participant in the operation and maintenance of equipment. The purchase price must also cover the cost of maintenance and upkeep of equipment;
 - Ensuring that providers of equipment and supplies are enrolled with the MO HealthNet Division (MHD) as a State Plan Durable Medical Equipment (DME) provider, or be registered and in good standing with the Missouri Secretary of State's Office; and
 - Ensuring providers for EAA are qualified and meet all state and local licensure and/or certification requirements. Contractors must have any required business licenses and meet all applicable building codes.
- Case Management (CM) assists participants in gaining access to needed waiver and other State Plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services needed.
 - **All** participants enrolled in the ILW shall be authorized for CM. Case managers employed by the HCBS provider must deliver and document at least 12 hours of CM per year, which includes at least monthly contact with the participant. One unit of CM equals up to one year of CM ([Policy 3.00, Appendix 1](#)).
 - CM may include any of the following activities:
 - Identification of abuse, neglect, and/or exploitation;
 - Monitoring the provision of services in the participant's care plan;
 - Review of the care plan and the participant's needs, which shall include monthly contacts and face-to-face visits with the participant as deemed necessary; and
 - Assisting participant with full access to a variety of services and service providers to meet their specific needs, regardless of funding source.
 - Environmental Accessibility Adaptations (EAA) are physical adaptations to the participant's home

necessary to ensure the health and safety of the participant, and/or enable the participant to function with greater independence in the home and community. Authorization of EAA is limited to \$5,000 in a five year period. A unit is based on the actual cost of work ([Policy 3.00, Appendix 1](#)).

- Examples of appropriate modifications include:
 - The installation of ramps and grab-bars, widening of doorways, and the modification of bathroom facilities;
 - Installation of specialized electric and plumbing systems that is necessary for the safety of the participant; and
 - Other modifications that directly impact health and safety of the participant.
- Adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, etc., are excluded.
- EAA may only be authorized when the FMS provider has verified and documented that no other resources are available to meet the need.
- Participants that live in rental property shall first request the landlord make any necessary modifications and/or give permission for the work to be done.
- Specialized Medical Equipment (SME) includes devices, controls, or appliances that enable participants to increase their ability to perform activities of daily living. Authorization of SME is limited to \$5,000 in a five year period. A unit is based on the actual cost of the device ([Policy 3.00, Appendix 1](#)). Examples include:
 - Lift chairs, commode chairs, patient lifts, trapeze equipment, oxygen, respiratory equipment, shower benches, augmentative communication devices, canes, walkers, or wheelchairs.
- Specialized Medical Supplies (SMS) include items that will enable a participant to increase their ability to perform activities of daily living. A unit is based on the actual cost of supplies ([Policy 3.00, Appendix 1](#)).
 - Examples include incontinence supplies, such as adult diapers and disposable bed pads;
 - When a participant currently receives incontinence supplies through the Medicaid exception process and the participant is being enrolled in the ILW, staff shall request authorization of SMS through the ILW.

EAA, SME, and SMS shall be authorized **only** when it can be documented that such authorization will decrease the current authorization of or future need for personal care assistance services, either through the State Plan or the ILW.

SME and SMS shall be authorized **only** when it can be documented that these services cannot be covered by another source, such as Medicaid or Medicare covered Durable Medical Equipment.

COST MAXIMUM

ILW expenditures must be cost effective in comparison to nursing facility costs based on the aggregate of all ILW participants' services.

- Cost effectiveness of the ILW is managed by Division of Senior and Disability Services (DSDS), Bureau of Long Term Services and Supports (BLTSS) as an administrative function.

PROVIDER CHOICE

ILW participants must select a Home and Community Based Services (HCBS) provider that is enrolled as a CDS provider with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance Unit (MMAC).

- The participant is considered the employer of record; and
- Payment is made to the HCBS provider on behalf of the participant.

LIMITATIONS AND WAITING LIST

The ILW is limited to a specific number of unduplicated participants during any waiver year:

- The ILW year runs from April 26 of each year through April 25 of the following year;
- Once a slot has been filled during the current waiver year, it cannot be used again in the same waiver year if the original participant leaves the ILW for any reason.
- BLTSS will notify regional staff when slots are available.

If all available slots are full when a participant is determined eligible for the ILW, the participant will be placed on the ILW Waiting List.

Information from the participant's official case record in the HCBS Web Tool is transferred to the Acuity Based Worksheet by BLTSS staff. The Acuity Total from this worksheet determines the participant's position on the ILW Waiting List.

- The Acuity Total is determined by transferring the times and tasks from the Care Plan Supplement for CDS developed with the participant to the priority categories listed on the Acuity Based Worksheet.
- Any changes to the participant's Acuity Total shall be updated on the ILW Waiting List.
- Participants with the highest Acuity Total will be considered first for any available slots.
- A participant's position on the ILW Waiting List may change from day-to-day based on the addition or deletion of other participants to the list.

The ILW Waiting List is managed and maintained by designated staff in BLTSS as part of required waiver oversight functions. At the beginning of each ILW year, BLTSS will notify each region of any available slots and provide a list of participants from the ILW Waiting List to be contacted.

- Regional staff shall contact participant(s) at that time to re-verify eligibility for ILW enrollment and confirm continued need for ILW services using the process outlined below.

PROCESS

When the potential need for an ILW service is identified during an assessment or other participant contact, DSDS staff shall complete the following as part of the [Person Centered Care Planning \(PCCP\)](#) process.

- Verify participant's age, Medicaid eligibility status, and ME code;
- Ensure participant is or will be enrolled in state plan CDS;
 - Persons with a cognitive impairment who choose to designate another person to direct their services shall be enrolled for CDS in the ILW (when a slot is available) as they are not eligible for State Plan CDS;
 - Verify that participants already receiving State Plan CDS are consistently utilizing those services.
- Verify that participant is not enrolled in any other waiver;
- Ensure the participant's case record in the HCBS Web Tool contains an HCBS Participant Choice Statement signed within the last 365 days;
- Review the participant's case to ensure that information regarding participant's needs is consistent throughout; e.g. needs identified during the assessment coordinate with the services and tasks to be authorized;
- Update existing case information as needed to reflect correct marital status/living arrangement, physician, responsible party, safety concerns, and other information relevant to care planning;
- Verify and document participant's ability to self-direct their care;
- Verify and document with the provider and/or participant that services requested are not available from any other resource;
- Complete and upload a draft CDS worksheet ([HCBS-3c](#)) that reflects all State Plan CDS and ILW services and tasks needed. The worksheet shall provide clear explanation of why each task is being requested and why the amount of time requested is appropriate;
 - When other services are or will be authorized, DSDS staff shall complete a draft In- Home Services ([HCBS-3a](#)) worksheet to indicate which services and tasks will be included.
- Document all contacts and actions in Case Notes, including any changes since the last assessment, unmet needs, support systems, a reference to the uploaded worksheet(s), and other issues that impact the need for services not already outlined in the worksheet.

DSDS staff shall submit the request for ILW services to their supervisor for review. The supervisor shall review all requests for ILW to ensure all steps are complete and the participant's unmet needs require the service(s) requested.

- If documentation supports the request, the supervisor shall forward the request to BLTSS waiver account for review prior to authorization of ILW services.
- Pending approval from BLTSS to authorize ILW, State Plan CDS shall be authorized up to 60% of the current cost maximum, depending on participant need.

BLTSS will review the ILW request and, if necessary, request clarification or additional details.

- The supervisor will be notified if the request is not approved for any reason;
 - Denial of a request for ILW enrollment requires DSDS staff to send a Notice of Adverse Action ([HCBS-12](#)) to the participant and is subject to appeal rights ([Policy 5.00](#) and [Policy 6.00](#)).

- Upon approval of a request, BLTSS will determine if an ILW slot is available, and:
 - Notify the supervisor to enroll the participant; or
 - Complete an Acuity Based Worksheet to determine the participant's needs and placement on the ILW Wait List, upload the form to the participant's case record in the HCBS Web Tool, and notify the supervisor of the decision.
 - EAA, SMS, and SME require additional documentation be obtained by BLTSS and may not be authorized until specific approval is given by BLTSS.

When a participant is placed on the ILW Waiting List, the participant has ninety (90) business days to appeal their number on the list.

- DSDS staff shall complete a Waiting List Notice for ILW Services ([HCBS-12W](#)) and forward to the participant, along with a copy of the Acuity Based Worksheet.
- Lack of an available slot in the ILW is **not** subject to adverse action and appeal rights.

Once a participant has been placed on the ILW Waiting List, regional staff shall notify BLTSS of all changes made to the participant's PCCP, including:

- Addition or deletion of services and tasks, whether during reassessment or resulting from other contacts;
- Suspension of services;
- Case closing; and/or
- Any action affecting participant's eligibility or need for ILW services.

BLTSS will update the Acuity Based Worksheet and the participant's information on the ILW Waiting List as necessary.

NOTE: When a reassessment is completed by a DSDS designee and identifies a need for ILW services, DSDS staff shall follow the same process to verify eligibility and need for ILW services before submitting the request to BLTSS.

Authorization of State Plan CDS and ILW Services in the HCBS Web Tool

The following will guide prior authorization for both State Plan CDS and ILW services upon approval from BLTSS.

'Personal Care – Consumer Directed Model' (State Plan) authorization:

- On the Prior Authorization Line Item screen for 'Personal Care – Consumer Directed Model' ensure selection of all tasks needed in the 'Task Detail Line Item'. The total of all tasks will display in the 'Total Units/Month' field.
 - Tasks selected in the Task Detail Line item of the 'Personal Care – Consumer Directed Model' shall reflect **all** of the personal care needs identified in the assessment and PCCP process.
- Select the box 'ILW Services' to enable manual entry into the 'Total Units/Month' field, for 'Personal Care – Consumer Directed Model'.

- In the 'Total Units/Month' field, manually enter the monthly unit maximum for 'Personal Care – Consumer Directed Model' ([Appendix 2](#)).
- The tasks displayed in the 'Task Detail Line Item' remain unchanged.
- Select the HCBS provider.
- Approve and save the Prior Authorization Line Item for 'Personal Care – Consumer Directed Model'.

'Consumer Directed Personal Care, Independent Living Waiver' authorization:

- Select 'Add a New Service' from the Prior Authorizations menu list on the Prior Authorization Detail screen.
- Select 'Consumer Directed Personal Care, Independent Living Waiver' from the drop down menu of available services in the Prior Authorization Line Item screen.
- In the 'Task Detail Line Item' enter the total units per month needed that exceed the monthly unit maximum for State Plan Personal Care – Consumer Directed Services.
 - Specific personal care task selection is not enabled in the 'Task Detail Line Item' as all of the personal care tasks needed are reflected in the previously completed Prior Authorization Line Item for 'Personal Care-Consumer Directed Model'.
- Save the task detail line.
- Select the HCBS provider.
- Approve and save the Prior Authorization Line Item for 'Consumer Directed Personal Care, Independent Living Waiver'.

Authorization of FMS:

- A line of FMS within a prior authorization-care plan is automatically created in the 'Authorized Services Section' of the Prior Authorization Detail screen when the Consumer-Directed Personal Care Independent Living Waiver is approved.
 - The service of FMS is **not** available from the Service Type drop down list within the HCBS Web Tool for manual selection.
- FMS displays in an approved status with the same provider and dates of service as the Consumer-Directed Personal Care Independent Living Waiver. These fields are editable as needed. At any time the dates or provider are edited on the Consumer-Directed Personal Care Independent Living Waiver line, FMS displays the newly edited information.
- The 'Total Units/Month field' and the 'Task Detail Line Item' auto populate with '1' and are read only.
- When Consumer-Directed Personal Care Independent Living Waiver service is deleted, FMS is deleted.
- FMS does not copy to a new Prior Authorization (PA) from a previously posted Prior Authorization that contains FMS. On the copied PA, once Consumer-Directed Personal Care Independent Living Waiver is approved, FMS automatically displays as previously described.

'Case Management – Independent Living Waiver' authorization:

- Select 'Add a New Service' from the Prior Authorizations menu list on the Prior Authorization Detail screen.
- Select 'Case Management – Independent Living Waiver' from the drop down menu of available services in the Prior Authorization Line Item screen.
 - The 'Total Units/Month field' and the 'Task Detail Line Item' auto populate with '1' and are read only.
 - Modify the 'Effective Date' and 'End Date' to reflect the first full month following (re)authorization of services.
 - o Example: 3/1/2019 - 3/31/2019; 9/1/2019 – 9/30/2019; etc.
- Select the HCBS provider.
- Approve and save the Prior Authorization Line Item for 'Case Management – Independent Living Waiver'

SME, EAA, or SMS authorization:

- Select 'Add a New Service' from the Prior Authorizations menu list on the Prior Authorization Detail screen.
- Select the approved ILW service from the drop down menu of available services in the Prior Authorization Line Item.
 - In the 'Task Detail Line Item' enter the number of units based on the actual cost approved through consultation with BLTSS and the HCBS provider.
- Select the HCBS provider.
- Approve and save the Prior Authorization Line Item.

Upon completion of all services to be authorized, review the entire authorization and submit the authorization on the Prior Authorization Header Screen.