HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services proposes to amend Chapter 81, "Nursing Facilities," Iowa Administrative Code.

These amendments pertain to the Preadmission Screening and Resident Review (PASRR) process. These amendments eliminate the use of the term "mental retardation," which has become obsolete. The term "intellectual disability" has become widely adopted and is preferred by the disability community. These amendments provide clarification to the PASRR process by more explicitly stating the PASRR requirements and updating the list of entities responsible for completing PASRR reviews. These amendments also provide clarification in regard to the nursing facility's role in requesting a state fair hearing after a PASRR determination by requiring that a facility obtain informed consent of the resident prior to requesting a hearing on the resident's behalf.

These amendments add facilities licensed as intermediate care facilities for persons with mental illness (ICFs/PMI) to the definition of a "special population nursing facility." There are three such facilities in the state, and all currently seek an annual exception to policy to allow them to be paid as special population facilities. This change will eliminate the need for an exception to policy. These amendments also formalize Department policy that Medicaid funding is only available to residents of ICFs/PMI who are aged 65 or older. These amendments are in accordance with the prohibition on Medicaid payment in an institution for mental disease set forth in 42 CFR 435.1010.

Section 2702 of the Patient Protection and Affordable Care Act prohibits federal payments for any amounts expended for health care-acquired conditions. The federal

regulations to implement the requirement at 42 CFR 447.26 specify that payment cannot be made for other provider-preventable conditions for any health care setting. These amendments define the term “surgical or other invasive procedure” and specify that Medicaid will not pay for days in a nursing facility when the wrong surgical or other invasive procedure is performed on a patient or a surgical or other invasive procedure is performed on the wrong body part of a patient or on the wrong patient.

In 2012, the Iowa Legislature directed the Department to allow nursing facilities to collect additional payment above the Medicaid payment from residents and families who desire a private room. This direction included a limitation in which facilities could charge the additional amount for a private room only when the facility occupancy was at least 80 percent. In the 2014 legislative session, 2014 Iowa Acts, House File 2463, section 87, changed the minimum occupancy rate to 50 percent and directed the Department to collect data annually on the utilization of this option. These amendments implement the directive from the Legislature.

These amendments align rules with Department policy related to inclusion of certain costs in the nursing facility per diem rate. The amendments also clarify that payment for reserve bed days is allowed for the state-run Iowa Veterans Home, in order to maximize federal funding within that facility’s budget.

Finally, these amendments provide technical corrections to an incorrect cross reference, remove references to obsolete Department forms, and remove language that was added in anticipation of a Medicaid state plan amendment which did not receive federal approval.

Notice of Intended Action was published in the Iowa Administrative Bulletin as

ARC 1683C on October 15, 2014.

The Department received comments from one respondent during the public comment period. The comments and the Department's responses are as follows:

Comment 1: The respondent stated concerns regarding proposed rule 81.3(3)(f) where if a nursing facility is requesting an administrative hearing regarding a PASRR determination must now receive prior, express, signed, written consent of the resident or the resident's legal representative.

Response 1: The PASRR determinations to which this rule applies are not decisions made directly against a nursing facility, but rather are decisions that specifically affect the individual's eligibility for care within a nursing facility. The department is aware of situations where appeals have been requested by nursing facilities on behalf of residents without the resident's knowledge. This rule seeks to assure that residents are fully informed that their private Protected Health Information (PHI) could be disclosed during a hearing and could become public in the course of the hearing or any subsequent appeals or judicial proceedings. Obtaining the resident's written permission to request an appeal will be beneficial to the facility as a safeguard to protect against committing inadvertent disclosures that could violate the Health Insurance Portability and Accountability Act (HIPAA). In cases where a resident has impaired cognition and lacks the capacity for independent decision making, the facility should proactively work with the resident and family to establish a substitute decision maker. If a family member is not available to fulfill this role, assistance can be provided by the Iowa Department on Aging's Office of Substitute Decision Maker. The Department made no changes to these amendments based on this comment.

Comment 2: In proposed rule 81.7(2), the definition of "significant change" appears to be overly broad by requiring that a nursing facility within 24 hours, initiate a PASRR review when there is, "any change defined as significant in the minimum data set". By requiring a PASRR review when there is any change as defined as significant in the minimum data set will undoubtedly result in unnecessary reviews that will result in the inefficient delivery of care and an associated increased cost to providers. According to the MDS 3.0 manual (page 2-20 attached below), a "significant change" is a decline or improvement in a resident's status that: 1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting" (for declines only); 2)i impacts more than one area of the resident's health status; and 3) requires interdisciplinary review and/or revision of the care plan. By looking at that definition and applying the proposed rule change, nursing facilities would be forced to initiate a PASRR review when a resident has a urinary tract infection or any other type of medical diagnosis not related to mental health status. By requiring a nursing facilities to initiate PASRR reviews in a variety of circumstances that do not relate to mental health status creates inefficiencies and will increase costs to providers. By merely striking the any change defined as significant in the minimum data set and retaining the rest of the proposed rule, we believe the intent of the Department will be fulfilled. Another option for the Department to consider would be to modify the proposed rule so that it would read significant change related to mental health status.

Response 2: The Department agrees with the comment and will revise subrule 81.7(2) to remove the language "or any change defined as significant in the minimum data set". ITEM 7 will be revised as follows:

81.7(2) PASRR. ~~Within the fourth calendar quarter after the previous review, the PASRR contractor shall review all nursing facility residents admitted pursuant to paragraph 81.3(3)"e" to~~ As a condition of payment for nursing facility care under the Medicaid program when there is a significant change in a resident's condition, the nursing facility shall, within 24 hours, initiate a PASRR review by the department's contractor for PASRR evaluations. For purposes of this subrule, "significant change in a resident's condition" means any admission or readmission to the facility immediately following an inpatient psychiatric hospitalization, or any change that is likely to impact the resident's treatment needs related to a mental illness or intellectual disability, ~~or any change defined as significant in the minimum data set~~. The evaluation shall determine:

a. Whether nursing facility care or skilled nursing care is medically necessary and appropriate for the resident under 441—subrules 79.9(1) and 79.9(2);

~~a~~b. Whether nursing facility services continue to be appropriate for the resident, as opposed to care in a more specialized facility or in a community-based setting, and

~~b~~c. Whether the resident needs specialized services for mental illness or ~~mental retardation~~ intellectual disability, as described in paragraph 81.3(3)"b."

Comment 3: In proposed rule 81.10(j), the effect is a prohibition of payment for days of care attributable to preventable conditions that develop "while an individual is a resident of a nursing facility". As such preventable conditions are defined as "surgical or invasive procedures", which are very rarely performed In nursing facilities. That being said, reading the rule as written, it would apply in scenarios where conditions arising from procedures performed elsewhere, and thus out of the control of the nursing facility. To solve this problem, we would recommend re-wording the provision so it reads

reimbursement will not be made for patient days attributable to preventable conditions identified pursuant to this rule that develop in a nursing facility.

Response 3: The department agrees with the comment and will revise ITEM 9, specifically paragraph **81.10(4)"j"** as follows:

j. Nonpayment for provider-preventable conditions. Reimbursement will not be made for patient days attributable to preventable conditions identified pursuant to this rule that develop ~~while an individual is a resident of~~ in a nursing facility. Any patient days attributable to a provider-preventable condition must be billed as noncovered days. A provider-preventable condition is one in which any of the following occur:

(1) The wrong surgical or other invasive procedure is performed on a resident; or

(2) A surgical or other invasive procedure is performed on the wrong body part; or

(3) A surgical or other invasive procedure is performed on the wrong resident.

The Council on Human Services adopted these amendments on December 10, 2014.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

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

These amendments will become effective March 1, 2015.

The following amendments are adopted.

ITEM 1. Amend rule **441—81.1(249A)**, definitions of "Level I review," "PASRR" and "Special population nursing facility," as follows:

"Level I review" means screening to identify persons suspected of having mental illness or ~~mental retardation~~ intellectual disability as defined in 42 CFR 483.102 as amended to ~~October 1, 2010~~ July 1, 2014.

"PASRR" means ~~the preadmission screening and annual review of persons with mental illness, mental retardation or a related condition~~ a Level I screening or a Level II evaluation for mental illness or intellectual disability for all persons who live in or seek entry to a Medicaid-certified nursing facility, as required by 42 CFR Part 483, Subpart C, as amended to ~~October 1, 2010~~ July 1, 2014.

"Special population nursing facility" refers to a nursing facility that serves the following populations:

1. One hundred percent of the residents served are aged 21 and under and require the skilled level of care.

2. Seventy percent of the residents served require the skilled level of care for neurological disorders.

3. One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness.

ITEM 2. Adopt the following **new** definition of "Surgical or other invasive procedure" in rule **441—81.1(249A)**:

"Surgical or other invasive procedure" means an operative procedure in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Surgical or other invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and

deep cryotherapy for malignant lesions) to extensive multiorgan transplantation. Surgical or other invasive procedures include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) published by the American Medical Association and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. Surgical or other invasive procedures include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. "Surgical or other invasive procedure" does not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

ITEM 3. Amend rule 441—81.3(249A) as follows:

441—81.3(249A) Initial approval for nursing facility care.

81.3(1) Need for nursing facility care. Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

a. Decisions on level of care, subject to paragraph 81.3(1)"b," shall be made for the department by the Iowa Medicaid enterprise (IME) medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

b. For residents subject to a Level II PASRR review pursuant to subrule 81.3(3),

the level of care determination shall be made as part of the Level II PASRR review, based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

~~b.~~ c. Adverse level of care decisions ~~by the IME medical services unit~~ may be appealed to the department pursuant to 441—Chapter 7.

81.3(2) Skilled nursing care level of need. Rescinded IAB 7/11/01, effective 7/1/01.

81.3(3) Preadmission review. The ~~IME medical services unit~~ department's contractor for PASRR screening and evaluation shall complete a Level I review for all persons seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the person's care. When a Level I review identifies evidence for the presence of mental illness or ~~mental retardation~~ intellectual disability, the department's contractor for PASRR evaluations shall complete a Level II review before the person is admitted to the facility.

a. Exceptions to Level II review. Persons in the following circumstances may be exempted from Level II review based on a categorical determination that in that circumstance, admission to or residence in a nursing facility is normally needed and the provision of specialized services for mental illness~~, mental retardation, or related conditions~~ or intellectual disability is normally not needed.

(1) to (5) No change.

(6) The person has dementia in combination with ~~mental retardation or a related condition~~ an intellectual disability.

(7) to (9) No change.

b. Outcome of Level II review. The Level II review shall determine ~~whether the person seeking admission~~:

(1) Whether nursing facility care or skilled nursing care is medically necessary and appropriate under 441—subrules 79.9(1) and 79.9(2) for the person seeking admission;

~~(1)~~ (2) ~~Needs~~ Whether the person seeking admission needs specialized services for mental illness as defined in paragraph 81.13(14)"b," using the procedures set forth in 42 CFR 483.134 as amended to ~~October 1, 2010~~ July 1, 2014; ~~or~~ and

~~(2)~~ (3) ~~Needs~~ Whether the person seeking admission needs specialized services for ~~mental retardation or a related condition~~ intellectual disability as defined in paragraph 81.13(14)"c," using the procedures set forth in 42 CFR 483.136 as amended to ~~October 1, 2010~~ July 1, 2014.

c. The department's division of mental health and disability services or its designee shall review each Level II evaluation and plan for obtaining needed specialized services before the person's admission to a nursing facility to determine whether nursing facility care or skilled nursing care is medically necessary and whether the nursing facility is an appropriate placement.

d. Nursing facility payment under the Iowa Medicaid program will be made for Medicaid members residing in the nursing facility:

(1) Only if a Level I review was completed prior to admission;

(2) For persons with mental illness~~, mental retardation, or a related condition~~ or intellectual disability, only if a Level II review has been completed, or an exception under paragraph 81.3(3)"a" has been approved, and it is determined by the division of mental health and disability services that nursing facility care or skilled nursing care is medically

necessary and appropriate and that the person's treatment needs related to a mental illness or intellectual disability will be or are being met.

e. Adverse PASRR decisions may be appealed to the department pursuant to 441—Chapter 7.

f. A nursing facility requesting an administrative hearing regarding a PASRR determination must have the prior, express, signed, written consent of the resident or the resident's lawfully appointed guardian to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the nursing facility submits a document providing such resident's consent to the request for a state fair hearing. The document must specifically inform the resident that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the resident's knowledge of the potential for PHI to become public and that the resident knowingly, voluntarily, and intelligently consents to the nursing facility bringing the state fair hearing on the resident's behalf.

81.3(4) Special care level of need. Rescinded IAB 3/20/91, effective 3/1/91.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)"a" and 249A.4.

ITEM 4. Amend paragraph **81.6(10)"a"** as follows:

a. Routine daily services shall represent the established charge for daily care. Routine daily services include room, board, nursing services, therapies, and such services as supervision, feeding, pharmaceutical consulting, over-the-counter drugs, incontinency, and similar services, for which the associated costs are in nursing service. Routine daily

services shall not include:

(1) Laboratory or ~~X-ray~~ diagnostic radiology services, unless the service is provided by facility staff using facility equipment, and

(2) Prescription (legend) drugs.

ITEM 5. Amend subrule 81.6(11) as follows:

81.6(11) Limitation of expenses. Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. to p. No change.

q. Prescription (legend) drug costs are excluded from services covered as part of the nursing facility per diem rate as set forth in paragraph 81.10(5)"~~c~~ d." The Iowa Medicaid program will provide direct payment for drugs covered pursuant to 441—subrule 78.1(2) to relieve the facility of payment responsibility. As Medicaid reimburses pharmacy providers only for the cost and dispensation of legend drugs included on the Medicaid preferred drug list, no drug costs will be recognized for other payor sources.

r. to t. No change.

u. Laboratory costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

v. Diagnostic radiology costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

ITEM 6. Rescind paragraphs **81.6(20)"c"** and **"d."**

ITEM 7. Amend subrule 81.7(2) as follows:

81.7(2) PASRR. ~~Within the fourth calendar quarter after the previous review, the PASRR contractor shall review all nursing facility residents admitted pursuant to paragraph 81.3(3)"e" to~~ As a condition of payment for nursing facility care under the Medicaid program when there is a significant change in a resident's condition, the nursing facility shall, within 24 hours, initiate a PASRR review by the department's contractor for PASRR evaluations. For purposes of this subrule, "significant change in a resident's condition" means any admission or readmission to the facility immediately following an inpatient psychiatric hospitalization, or any change that is likely to impact the resident's treatment needs related to a mental illness or intellectual disability. The evaluation shall determine:

a. Whether nursing facility care or skilled nursing care is medically necessary and appropriate for the resident under 441—subrules 79.9(1) and 79.9(2);

~~a.~~ b. Whether nursing facility services continue to be appropriate for the resident, as opposed to care in a more specialized facility~~,~~ or in a community-based setting; and

~~b.~~ c. Whether the resident needs specialized services for mental illness or ~~mental retardation~~ intellectual disability, as described in paragraph 81.3(3)"b."

ITEM 8. Amend paragraph **81.10(4)"f"** as follows:

f. ~~Effective December 1, 2009, payment~~ Payment for periods when residents are absent for a visit, vacation, or hospitalization shall be made at zero percent of the nursing facility's rate, except for special population facilities and state-operated nursing facilities, which shall be paid for such periods at 42 percent of the facility's rate.

ITEM 9. Adopt the following **new** paragraphs **81.10(4)"i"** and **"j"**:

i. Payment for residents of a special population facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness will be made only when the resident is aged 65 or over. If a resident under age 65 is admitted with a payment source other than Medicaid, the facility shall notify the resident, or when applicable the resident's guardian or legal representative, that Iowa Medicaid may neither make payment to the facility nor make payment for any other services rendered by any provider while the person resides in the facility, until the resident attains the age of 65.

j. Nonpayment for provider-preventable conditions. Reimbursement will not be made for patient days attributable to preventable conditions identified pursuant to this rule that develop in a nursing facility. Any patient days attributable to a provider-preventable condition must be billed as noncovered days. A provider-preventable condition is one in which any of the following occur:

(1) The wrong surgical or other invasive procedure is performed on a resident; or

(2) A surgical or other invasive procedure is performed on the wrong body part; or

(3) A surgical or other invasive procedure is performed on the wrong resident.

ITEM 10. Amend paragraph **81.10(5)"c"** as follows:

c. The Medicaid program will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services that meet the Medicare definition of medical necessity and are provided by ~~vendors~~ providers enrolled in the Medicaid programs including:

(1) Physician services.

(2) Ambulance services.

(3) Hospital services.

(4) Hearing aids, braces and prosthetic devices.

~~(5) Therapy services.~~

~~(6)~~ (5) Customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2)"a"(4).

ITEM 11. Amend subparagraph **81.10(5)"e"(4)** as follows:

(4) Supplementation for provision of a private room not otherwise covered under the medical assistance program, subject to the following conditions, requirements, and limitations:

1. and 2. No change.

3. Supplementation for provision of a private room is not permitted for a calendar month if the facility's occupancy rate was less than ~~80~~ 50 percent as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

4. to 10. No change.

11. A nursing facility that utilizes the supplementation pursuant to this subparagraph during any calendar year shall report to the department annually by January 15 the following information for the preceding calendar year:

- The total number of nursing facility beds available at the nursing facility, the number of such beds available in private rooms, and the number of such beds available in other types of rooms.
- The average occupancy rate of the facility on a monthly basis.
- The total number of residents for whom supplementation was utilized.
- The average private pay charge for a private room in the nursing facility.

● For each resident for whom supplementation was utilized, the total charge to the resident for the private room, the portion of the total charge reimbursed under the Medicaid program, and the total charge reimbursed through supplementation.

ITEM 12. Adopt the following **new** paragraph **81.10(5)"j"**:

j. The facility shall not charge a resident for days that are not covered under Medicaid due to a provider-preventable condition pursuant to paragraph 81.10(4)"j" and shall not discharge a resident due to nonpayment for such days.

ITEM 13. Amend subrule 81.11(1) as follows:

81.11(1) Claims. Claims for service must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Claims ~~may~~ must be submitted electronically ~~on software provided by the Iowa Medicaid enterprise or in writing on Form 470-0039~~ through Iowa Medicaid's electronic clearinghouse.

~~a. When payment is made, the facility will receive a copy of Form 470-0039, Iowa Medicaid Long-Term Care Claim. The white copy of the form shall be signed and returned to the Iowa Medicaid enterprise as a claim for the next month. If the claim is submitted electronically, the facility will receive~~ A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system.

~~b. When there has been a new admission or a discharge, the facility shall submit Form 470-0039 with the changes noted. When a change is necessary to adjust a previously paid claim, the facility shall submit Form 470-0040, Credit/Adjustment Request.~~ Adjustments to ~~electronically~~ submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise. A request for an adjustment to a paid claim must be received by the Iowa Medicaid enterprise within one year from the date the claim was paid

in accordance with rule 441—80.4(249A).

ITEM 14. Amend paragraph **81.13(14)"c"** as follows:

c. Specialized services for ~~mental retardation or a related condition~~ intellectual disability. "Specialized services for ~~mental retardation or a related condition~~ intellectual disability" means services that:

(1) to (3) No change.

(4) Must be supervised by a qualified ~~mental retardation~~ intellectual disability professional; and

(5) No change.

ITEM 15. Amend subrule 81.22(2) as follows:

81.22(2) Beginning date of payment. When a resident becomes eligible for Medicaid payments for facility care, the facility shall accept Medicaid rates effective when the resident's Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

Any refund owing shall be made no later than 15 days after the nursing facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident's client participation for the month from a refund of the amount paid for a month of Medicaid eligibility.

The beginning and renewal date of eligibility ~~is given on the Facility Card, Form 470-0371~~ and resident client participation amounts may be obtained through the Iowa Medicaid portal access (IMPA) system. When the beginning Medicaid eligibility date is a future month, the facility shall accept the Medicaid rate effective the first of that future

month.

Information on Proposed Rules

Name of Program Specialist	Telephone Number	E-mail Address
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1. Give a brief summary of the rule changes:

Items 1, 2, and 18 - Replaces the phrase “mental retardation” with the more widely accepted term “intellectual disability”.

Item 3 – Adds facilities licensed as Intermediate Care Facility for Persons with Mental Illness (ICF/PMI) to the definition of special population facilities.

Item 4 – Adds a definition related to provider preventable conditions language in Item 11.

Items 5 and 10 - Replaces the phrase “mental retardation” with the more widely accepted term “intellectual disability”; and clarifies responsibilities for the level of care (LOC) determination process and the Preadmission Screening and Resident Review (PASRR) process, including language requiring a facility to gain a resident’s consent for the facility to request a state fair hearing related to a PASRR determination.

Item 7 – Technical correction to cross reference the correct paragraph.

Items 6, 8 and 13 – Clarifies policy related to inclusion of certain costs in the nursing facility per diem rate and changes corresponding language for consistency.

Item 9 – Removes obsolete language related to a Medicaid state plan amendment that never received federal approval.

Item 11 – Clarifies current policy for payment of reserve bed days to the Iowa Veteran’s Home in order to maximize federal funding.

Item 12 – Adds a paragraph to clarify that Medicaid funding is only available to residents of ICF/PMI facilities that are age 65 or older pursuant to 42 USC § 1396d(a) and 42 CFR 435.1009. Also adds language prohibiting Medicaid payment for provider preventable conditions as required by 42 CFR 447.26

Items 14 and 15 - Changes the facility’s occupancy rate requirement for applicability of family supplementation in a private room from 80 percent to 50 percent. Establishes reporting requirements related to this change. This change was mandated by the 2014 session 85th General Assembly in HF 2463, section 87.

Item 16 – Adds language to prevent facilities from charging residents for days that were not payable by Medicaid due to a provider preventable condition.

Items 17 and 19 – Removes references to obsolete forms and provides updates on procedures that replace the obsolete forms.

2. What is the reason for the Department to request these changes?

LOC & PASRR - Changes are being made to eliminate the use of the term "mental retardation" with has become obsolete as the term "intellectual disability" has become widely adopted and is preferred by the disability community. Changes are also to provide clarification to the LOC and PASRR process by more explicitly stating the PASRR requirements, and updating the entities responsible for completing LOC and PASRR reviews. This includes clarification in regard to the nursing facility role in requesting a state fair hearing after a PASRR determination, to require that the facility obtain informed consent of the resident prior to requesting a hearing on the person's behalf.

Special Population Facilities - These changes add facilities licensed as an ICF/PMI to the definition of a special population facility. There are three such facilities in the state, and all currently seek an annual exception to policy to allow them to be paid as special population facilities. This change will allow them to continue as such without the need for an exception. These changes also formalizes current department policy that Medicaid funding is only available to residents of ICF/PMI facilities that are age 65 or older as required by the prohibition on Medicaid payment in an institution for mental disease set forth in 42 USC § 1396d(a) and 42 CFR 435.1009.

Provider Preventable Conditions - Section 2702 of the Affordable Care Act directed the Secretary of Health and Human Services to adopt regulations regarding payments for "health care-acquired conditions." The federal regulations to implement the requirement at 42 CFR 447.26 specify that payment cannot be made for "provider-preventable conditions," unless the condition of a particular patient existed prior to the initiation of any treatment of that patient by the provider treating the preventable condition. At a minimum, "provider-preventable conditions" must include the wrong surgical or other invasive procedure performed on a patient, such procedures performed on the wrong body part, or such procedures performed on the wrong patient. This rule change defines the term "surgical or other invasive procedure" as defined in guidance published by CMS, specifies that Medicaid will not pay for days in a nursing facility attributable to incorrect procedures performed in the facility, and prohibits the facility from charging the resident for such days or discharging the resident for nonpayment for such days.

Private Room Supplementation - In 2012 the Iowa Legislature directed the department to allow nursing facilities to collect additional payment above the Medicaid payment from residents and families who desire a private room. The 2012 legislation included the limitation that facilities could only charge the additional amount for a private room when the facility occupancy was at least 80 percent. In the 2014 legislative session, HF 2463, section 87 changed the minimum occupancy rate to 50% and directed the department to collect data annually on the utilization of this option. These rules changes implement the directive from the legislature.

Nursing Facility Payment - These changes align rules with current department policy related to inclusion of certain costs in the nursing facility per diem rate. They also clarify that payment for reserve bed days is allowed for the state-run Iowa Veteran's Home, in order to maximize federal funding within that facility's budget.

Technical Corrections – These changes are technical corrections to fix an incorrect cross-reference; to remove references to department forms that are obsolete; and to remove language that was added in anticipation of a Medicaid state plan amendment which never received federal approval.

3. What will be the effect of the rule adoption? (who, what, when, how)?

Most of these amendments will update language and clarify existing policy and processes, but will not impose any new requirements on providers or members. However, a few provisions will have an effect on providers:

- There will be a new requirement for nursing facilities to gain a resident's consent for the facility to request an appeal hearing related to a PASRR determination on the member's behalf. This will assure that the resident or their legal representative is informed about the potential for protected health information to become part of the proceeding, and will make sure the resident is aware and in agreement before a facility can file an appeal on the resident's behalf.
- Providers who charge residents or families a supplementary fee for a private room in a nursing facility will be required to report annually to the department regarding utilization of this option. The reduction of the minimum occupancy rate will allow more nursing facilities to collect additional amounts from Medicaid residents for private rooms.
- Facilities licensed as an ICF/PMI will be able to continue to be reimbursed as a special population facility without the need for an annual exception to policy request.
- Nursing facilities will not be able to bill Medicaid for days in the facility where the wrong surgical or other invasive procedure is performed on a patient, on the wrong body part, or on the wrong patient. This should have minimal impact, as invasive procedures are not routinely performed in nursing facilities.

4. Is the change mandated by State or Federal Law? (Cite the authorizing state and federal statutes and federal regulations)

- Changes related to private room supplementation are mandated by 2014 Iowa HF 2463, section 87.
- The change related to the prohibition on Medicaid funding for residents of ICF/PMI facilities that are age 65 or older is required for compliance with 42 USC § 1396d(a) and 42 CFR 435.1009.
- Changes related to provider preventable conditions are required for compliance with 42 CFR 447.26.

5. Will anyone be affected by this rule change? If yes who will be affected and will it be to the person(s) benefit or detriment?

The requirement for nursing facilities to gain a resident's consent for the facility to request an appeal related to a PASRR determination will add an extra step for facilities, but will also benefit residents by ensuring that they are informed about the potential for protected health information to become part of the proceeding prior to giving consent.

Nursing facility providers will benefit from the change in the minimum occupancy rate required to charge a supplementary fee for a private room, and residents who desire a private room will have greater opportunity as more providers make this option available.

Facilities licensed as an ICF/PMI will benefit because they will no longer need to request an exception to policy annually in order to be paid as a special population facility.

Facilities could potentially lose reimbursement for days when a provider preventable condition occurs, however, this should be minimal as most invasive procedures that would require nonpayment are not routinely performed in nursing facilities.

The clarification regarding payment for reserve bed days for the state-run Iowa Veteran's Home, will maximize federal funding for that facility, as the cost would otherwise be paid with state-only funds.

6.	What are the potential benefits of this rule? See #3 and #5 above.
7.	What are the potential costs, to the regulated community or the State of Iowa as a whole, of this rule? While some of these changes refer to Medicaid payment policies, most of these amendments are clarifications of current policies and processes, and as such there are no costs associated with these changes. The changes regarding supplementation for a private room in a nursing facility will likely increase revenue for these facilities. Residents whose families opt for private rooms will have an increased cost.
8.	Do any other agencies regulate in this area? If so, what agencies and what Administrative Code Sections apply? Iowa Department of Inspections and Appeals (DIA) performs licensing and certification functions for the nursing facilities and ICF/PMI facilities, but these changes do not affect DIA processes.
9.	What alternatives to direct regulation in this area are available to the agency? Why were other alternatives not used? As these are primarily technical changes and clarifications, and several are required by state law or federal regulation; as such there are no alternative approaches.
10.	Does this rule contain a waiver provision? If not, why? Specific waivers are not provided because the department has an established procedure for considering exceptions to policy. A waiver of any of these rules may be granted through that process.
11.	Do these rules have an impact on private-sector jobs and employment opportunities in Iowa? (If yes, describe nature of impact, categories and number of jobs affected, state regions affected, costs to employer per employee) These rule changes will have no effect on private-sector jobs or employment opportunities in Iowa.

ADMINISTRATIVE RULE FISCAL IMPACT STATEMENT

Date: July 11, 2014

Agency: Human Services
IAC citation: 441 IAC
Agency contact: Don Gookin

Summary of the rule:
Items 1, 2, and 18 - Replaces the phrase "mental retardation" with the more widely accepted term "intellectual disability".
Item 3 – Adds facilities licensed as Intermediate Care Facility for Persons with Mental Illness (ICF/PMI) to the definition of special population facilities.
Item 4 – Adds a definition related to provider preventable conditions language in Item 11.
Items 5 and 10 - Replaces the phrase "mental retardation" with the more widely accepted term "intellectual disability"; and clarifies responsibilities for the level of care (LOC) determination process and the Preadmission Screening and Resident Review (PASRR) process, including language requiring a facility to gain a resident's consent for the facility to request a state fair hearing related to a PASRR determination.
Item 7 – Technical correction to cross reference the correct paragraph.
Items 6, 8 and 13 – Clarifies policy related to inclusion of certain costs in the nursing facility per diem rate and changes corresponding language for consistency.
Item 9 – Removes obsolete language related to a Medicaid state plan amendment that never received federal approval.
Item 11 – Clarifies current policy for payment of reserve bed days to the Iowa Veteran's Home in order to maximize federal funding.
Item 12 – Adds a paragraph to clarify that Medicaid funding is only available to residents of ICF/PMI facilities that are age 65 or older pursuant to 42 USC § 1396d(a) and 42 CFR 435.1009. Also adds language prohibiting Medicaid payment for provider preventable conditions as required by 42 CFR 447.26
Items 14 and 15 - Changes the facility's occupancy rate requirement for applicability of family supplementation in a private room from 80 percent to 50 percent. Establishes reporting requirements related to this change. This change was mandated by the 2014 session 85th General Assembly in HF 2463, section 87.
Item 16 – Adds language to prevent facilities from charging residents for days that were not payable by Medicaid due to a provider preventable condition.
Items 17 and 19 – Removes references to obsolete forms and provides updates on procedures that replace the obsolete forms.

Fill in this box if the impact meets these criteria:

____ No fiscal impact to the state.

X Fiscal impact of less than $100,000 annually or $500,000 over 5 years.

____ Fiscal impact cannot be determined.

Brief explanation:
The majority of these amendments are technical changes and clarifications of current policy and procedure, and as such there should be little fiscal impact.
New policy changes within this rule include the occupancy rate requirement for family supplementation and payment limitations related to provider preventable conditions. The family supplementation changes will have no fiscal impact to the state. The provider preventable conditions restrictions could generate savings, but the impact is expected to be minimal as most invasive procedures that would require nonpayment are not routinely performed in nursing facilities.

Fill in the form below if the impact does not fit the criteria above:
Fiscal impact of $100,000 annually or $500,000 over 5 years.

Assumptions:

Describe how estimates were derived:

Estimated Impact to the State by Fiscal Year

	Year 1 (SFY15)	Year 2 (SFY16)
Revenue by each source:		
General fund		
Federal funds		
TOTAL REVENUE		
Expenditures:		
General fund		
Federal funds		
TOTAL EXPENDITURES		
NET IMPACT	<$100,000	<$100,000

____ This rule is required by state law or federal mandate.
Please identify the state or federal law:

____ Funding has been provided for the rule change.
Please identify the amount provided and the funding source:

__X__ Funding has not been provided for the rule.
Please explain how the agency will pay for the rule change:
No additional funding is needed as these changes are not expected to increase costs.

Fiscal impact to persons affected by the rule:
While some of these changes refer to Medicaid payment policies, most of these amendments are clarifications of current policies and processes, and as such there are no costs associated with these changes.
The changes regarding supplementation for a private room in a nursing facility will likely increase revenue for these facilities. Residents whose families opt for private rooms will have an increased cost.
Facilities could potentially lose reimbursement for days when a provider preventable condition occurs, however this should be minimal as most procedures that would require nonpayment are not routinely performed in nursing facilities.

Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):
None expected**.**

Agency representative preparing estimate: Joe Havig
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