

**Comments and Responses on ARC 2242C  
Medicaid Managed Care Omnibus  
Received December 4, 2015**

The following person/organization provided written comments, which are included in the summary below:

1. William Vaughn, President and CEO, Mainstream Living, Inc.
2. Larry Carl, Iowa Dental Association
3. Mark Dodd, Executive Director, North Iowa Transition Center
4. Ashley Habhab, Program Manager, Birch House, Hillcrest Family Services
5. Suzie Steger, Regulatory Coordinator, Accreditation Commission for Health Care (ACHC)
6. Lu Wingfield, Vice President of Mental Health Services, Mainstream Living, Inc.
7. Gail Murphy, Citizen
8. Barbara Owens, Citizen
9. Shelly Chandler, Executive Director, Iowa Association of Community Providers
10. Nancy Roberson, Citizen
11. Joy Cox, Operations Manager, Senior Housing Management
12. Jason Velinsky, Operations Director, Caretech, Inc.
13. Kay Morgan, Vice President of Drug Products & Industry Standards, Gold Standard
14. Denise Beenk, Director of Residential and Outreach Programs, Vera French Pine Knoll/CMHC
15. Kerry Weinbrandt, Citizen
16. Connie Williams, Recreation Therapy, Vera French Pine Knoll
17. Kristie Oliver, Executive Director, Coalition for Family & Children's Services in Iowa
18. Kelsey Clark, Executive Director, Iowa Behavioral Health Association
19. Kyle Carlson, Government Relations Director, Amerigroup Iowa, Inc.
20. renbarb70@aol.com
21. Bill Nutty, Vice President, Regulatory and Government Affairs, Iowa Healthcare Association
22. Rosemary Washburn, Director of Nursing, Vera French Pine Knoll
23. Theodore Boesen, CEO, Iowa Primary Care Association
24. George Eichhorn, General Counsel, Childserve
25. Susan Osby, Program Planner, Polk County Health Services
26. Jeremy Brigham, Citizen
27. Jennifer Donovan, Staff Attorney, Iowa Legal Aid
28. Judith Benson, Attorney At Law

Summary:

The Department received multiple comments from 28 respondents. The comments were lengthy and in many instances duplicative and were summarized within this document. An electronic copy of the comments are available upon request by email at [policyanalysis@dhs.state.ia.us](mailto:policyanalysis@dhs.state.ia.us).

The Department rules are not intended to reiterate all provisions of the managed care contracts or all applicable federal requirements. The Department's contracts with the MCOs require compliance with all applicable legal requirements.

Based on the public comments received the Department will be amending the proposed rules as follows:

- **74.11(4) “a”.** A Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations must be performed by a medical provider and must assess a member's overall physical health consistent with standard clinical guidelines for preventive physical examinations and as defined by the department. Oral examinations must be performed by a ~~dental provider~~ dentist consistent with standard oral health guidelines for preventive dental examinations and as defined by the department.

- ~~**441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies.**~~ All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program provided that the dealers are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

- **441-77.12(249A) Behavioral health intervention.** A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies:

The Joint Commission accreditation (TJC), or

The Healthcare Facilities Accreditation Program (HFAP), or

The Commission on Accreditation of Rehabilitation Facilities (CARF), or

The Council on Accreditation (COA), or

The Accreditation Association for Ambulatory Health Care (AAAHC).

Iowa Administrative Code Chapter 24, Accreditation of providers of services to persons with mental illness, intellectual disabilities or developmental disabilities

- **441—77.51(249A) Child care medical services.** Child care centers are eligible to participate in the medical assistance program when they comply with the standards of 441—Chapter 109. A child care center in another state is eligible to participate when duly licensed in that state. The provider of child care medical services implements a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, psychosocial, ~~and~~ developmental therapies and personal care required by the medically dependent or technologically dependent child served. Nursing services must be provided.

- **78.28(8)** ~~Nursing, personal care, or psychosocial~~ psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable

by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate per discipline.

- **78.57(2)** Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(4). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching pro-social skills and reinforcing positive interactions.

- **78.57(3)** Psychosocial services are those services that ~~teach pro-social skills and reinforce positive interactions~~ focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(4). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

- **78.57(3) "A"** Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(4). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individuals needs such as fine motor, gross motor, and receptive expressive language.

- **78.57(5)** Requirements.
  - a. Nursing, psychosocial, developmental therapies and personal care ~~Nursing, personal care, or psychosocial~~ services shall be ordered in writing.
  - b. Nursing, psychosocial, developmental therapies and personal care ~~Nursing, personal care, or psychosocial~~ services shall be authorized by the department or the department's designated review agent prior to payment.
  - c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The ~~treatment plan~~ plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- (1) Place of service.
- (2) Type of service to be rendered and the treatment modalities being used.
- (3) Frequency of the services.
- (4) Assistance devices to be used.
- (5) Date on which services were initiated.
- (6) Progress of member in response to treatment.
- (7) Medical supplies to be furnished.
- (8) Member's medical condition as reflected by the following information, if applicable:
  1. Dates of prior hospitalization.
  2. Dates of prior surgery.
  3. Date last seen by a primary care provider.
  4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
  5. Prognosis.
  6. Functional limitations.
  7. Vital signs reading.
  - ~~8. Date of last episode of instability.~~
  - ~~8~~9. Date of last episode of acute recurrence of illness or symptoms.
  - ~~9~~10. Medications.
- (9) Discipline of the person providing the service.
- (10) Certification period.
- (11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.
- (12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.

**Public Comment and Department Response:**

**COMMENT: 36.1 & 36.2 (3)** The respondent recommended that the Department bill this fee on a quarterly basis using claims paid data from the MCOs as was previously stated by the Department at the Medical Assistance Advisory Council (MAAC) Executive Council meeting.

**RESPONSE:** The Department will not be making any changes to this rule.  
The Department is neutral on moving to quarterly submission for the ICF/ID assessment fee; however, the Code of Iowa would need to change to reflect a quarterly collection of this fee.

**COMMENT: 74.11(4) "a"**. Respondent suggested the following amendment to the subrule. A Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations must be performed by a medical provider and must assess a member's overall physical health consistent with standard clinical guidelines for preventive physical examinations and as defined by the department. Oral examinations must be performed by a ~~dental provider~~ dentist consistent with standard oral health guidelines for preventive dental examinations and as defined by the department.

**RESPONSE:** The Department agrees with change. The rules will be changed as follows:

**74.11(4) "a"**. A Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations must be performed by a medical provider and must assess a member's overall physical health consistent with standard clinical guidelines

for preventive physical examinations and as defined by the department. Oral examinations must be performed by a ~~dental provider~~ dentist consistent with standard oral health guidelines for preventive dental examinations and as defined by the department.

**COMMENT:** Respondent stated that services are not available in many areas of the state yet MCOs are required to provide access and services. By paying MCOs and not requiring that they appropriately serve all members, the state is allowing MCOs to intentionally decrease service availability without repercussions. Managed Care Organizations should have more responsibility to serve members and not be paid when they have the excuse "no providers are available in the area. States that wording around time and distance thresholds should be in the regulations.

**RESPONSE:** The Department will not be making any changes to the rule. The requirements regarding provider access standards were included in the request for proposal and in the contract with the MCOs. All requirements of the MCOs are not included in the Iowa Administrative Code but are also in the RFP and the contract.

**COMMENT: 77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies** Respondent stated that requiring all dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or other states be certified to participate in Medicare would be a problem in areas where Medicare uses competitive bidding, as limited numbers of providers will be certified. It will also make specialty items that Medicaid covers but Medicare does not even harder to acquire for Medicaid recipients in Iowa.

**RESPONSE:** The Department agrees with this comment and will not implement this rule to assure access to this program. The Department will continue to look at how Medicare is implementing competitive bidding to see if this should be added in the future. Rule 441—77.10(249A) will remain as it is currently found in administrative rule.

**COMMENT: 77.12(249A) Behavioral health intervention.** Respondent would like ACHC to be included as an approved accreditation organization.

**RESPONSE:** The Department will not be making changes to this rule at this time. The Department would be interested in reviewing the ACHC Behavioral Health Accreditation Standards to determine if this type of accreditation would be applicable to Iowa Services. Please send information to the Bureau of Medical and Long Term Services and Supports, Bureau Chief, Deborah Johnson at [djohnso6@dhs.state.ia.us](mailto:djohnso6@dhs.state.ia.us).

**COMMENT: 77.12 Behavioral Health Intervention:** Respondent states that the proposed amended rule requires previously unaccredited Behavioral Health Intervention Providers to become accredited to continue to provide services. Requiring accreditation from the named accreditation bodies without a reasonable time frame for transition will decrease access to services for Iowans. We ask that a 12-month transition timeline be set to allow for providers who are not accredited the time necessary to complete the accreditation process.

**RESPONSE:** The Department will amend the proposed rule.

IAC 441.24, Accreditation of providers of services to persons with mental illness, intellectual disabilities or developmental disabilities, is an acceptable accreditation body for behavioral health interventions.

**441-77.12(249A) Behavioral health intervention.** A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies:

1. The Joint Commission accreditation (TJC), or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC).
6. Iowa Administrative Code Chapter 24, Accreditation of providers of services to persons with mental illness, intellectual disabilities or developmental disabilities

**COMMENT:** The respondent has a concern with this section because many BHIS providers were accredited and able to do BHIS services under Ch. 24. If CH. 24 is not an acceptable form of accreditation to provide BHIS services, many providers will close their programs and not be able to do the service.

**RESPONSE:** The Department will amend the proposed rule.

IAC 441.24, Accreditation of providers of services to persons with mental illness, intellectual disabilities or developmental disabilities, is an acceptable accreditation body for behavioral health interventions.

**441-77.12(249A) Behavioral health intervention.** A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies:

1. The Joint Commission accreditation (TJC), or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC).
6. Iowa Administrative Code Chapter 24, Accreditation of providers of services to persons with mental illness, intellectual disabilities or developmental disabilities

**COMMENT: 441-77.12(249A) Behavioral health intervention.** The respondent states this provision should include "services" after "behavioral health intervention" as Behavioral Health Intervention Services are a specific set of services requiring accreditation. If this change is not made, the provision reads as though all providers of behavioral health interventions must be accredited which would be a barrier for many primary care behavioral health service providers.

**RESPONSE:** The Department will amend the proposed rule.

IAC 441.24, Accreditation of providers of services to persons with mental illness, intellectual disabilities or developmental disabilities, is an acceptable accreditation body for behavioral health interventions. The Department will amend the proposed rule.

**441-77.12(249A) Behavioral health intervention.** A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies:

1. The Joint Commission accreditation (TJC), or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC).
6. Iowa Administrative Code Chapter 24, Accreditation of providers of services to persons with mental illness, intellectual disabilities or developmental disabilities

**COMMENT:** The Department received 11 comments requesting the Department to not rescind paragraphs relating to habilitation services provided by Residential Care Facilities (RCFs). Comments stated the rule change would impact RCF's and clients by forcing people out of stable mental health placements and into more expensive residential or institutional care, reduce choice for people with CMI, devalue the role of smaller RCFs and not allow enough time for process for existing providers due to the compressed time frame.

**RESPONSE:** The Department will not be changing the rule based on this comment as it has no effect on current practice. The rule is rescinding an outdated reference to the transition from Adult Rehabilitation Option to the current Habilitation program. The rescinded rule allowed one year for providers of ARO to become certified under the Habilitation standards. All providers should have transitioned during calendar year 2007. This proposed rule change does not prohibit RCF's from providing the service.

**COMMENT:** 77.25(3) "b" (2) and multiple references-Critical Incident Reporting-the Respondent recommends that the MCOs use Form 470-4698 to provide uniform reporting and ease for those completing the reports.

**RESPONSE:** The Department will not be making a rule change. Any critical incidence reporting form and criteria used by MCOs must be approved by the Department. The Department agrees that continuity of information with incident reporting is essential for all. The criteria must be the same as required by the Iowa Administrative Code. Some MCOs are utilizing the department's form.

**COMMENT:** Respondent asks about who will have access to the Supports Intensity Scale (SIS) assessment. Currently Form 470-3073 is available to the medical providers, Medicaid members, and the general public. Federal regulations at 42 CFR 438.236 establish standards for practice guidelines adopted by MCOs and require the dissemination of those practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees. DHS needs to ensure that any practice guidelines adopted by the MCOs and used to make decisions regarding eligibility or coverage are made available to providers, members, and the general public as required by federal regulation.

**RESPONSE:** The Department will not be making any changes to the rule. The Supports Intensity Scale has rigorous training and oversight requirements through the American Association on Intellectual and Developmental Disabilities. Each MCO will be required to follow these guidelines. Any decisions regarding eligibility including financial, functional or level of care will continue to be made by the Department. Reports are generated from the SIS to share with the case manager and family/member.

**COMMENT:** Rule 441-77.51 The Respondent is proposing the addition of a requirement for accreditation to establish a high standard for quality and participation, such as our CARF accreditation for Child & Youth Services.

**RESPONSE:** The Department will not be making changes to the rules. The State does not believe it is necessary to add an additional accreditation requirement under CARF or similar accrediting body, as the current language in this proposed subrule already requires compliance with 441—Chapter 109, which addresses care standards and related requirements applicable to child care centers under the purview of DHS. Further, to the extent this “enrollment requirement” rule allows for child care center providers in other states to participate, so long as they’re licensed in that (other) state, adding a CARF accreditation requirement may not be consistent with how other states license this type of provider.

**COMMENT:** Rule 441-77.51 The Respondent proposes use of consistent descriptions of services in all sections: "nursing, psychosocial, developmental therapies and personal care." to more accurately reflects the program.

**RESPONSE:** The Department agrees with the comment and will be making the following changes:

**441—77.51(249A) Child care medical services.** Child care centers are eligible to participate in the medical assistance program when they comply with the standards of 441—Chapter 109. A child care center in another state is eligible to participate when duly licensed in that state. The provider of child care medical services implements a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, psychosocial, ~~and~~ developmental therapies and personal care required by the medically dependent or technologically dependent child served. Nursing services must be provided.

**78.27 Home and Community Based habilitation services.**

The Department received 7 comments. 1) ISIS 2) Plan Approval Process 3) Needs Assessment 4-5) Plan for Service 6) Comprehensive Service or Treatment Plan 7) Adverse Service Actions

**COMMENT 1: 78.27- ISIS.** Respondent suggests all references to ISIS should be deleted as IME is no longer providing ISIS. Service plans are no longer entered into the ISIS system.

**RESPONSE:** The Department will not be making a rule change. The rules in these sections relate to the fee for service population and therefore, ISIS will continue to be used for the coordination of services for the fee for service members.

**COMMENT 2: 78.27(4) & (11) Plan Approval Process.** The Respondent requests clarification of this service and treatment plan approval process. Respondent states that the approval process is shifting to the IME Medical Service Unit, rather than the Managed Care contractor and is only being required for habilitation services.

**RESPONSE:** The Department will not be making changes to this rule. Rules in this section relate to fee for service individuals and providers, not those who are in the MCO. MCOs will be authorizing services for habilitation and the Iowa Medicaid Enterprise will be authorizing services for individuals in fee for service.

**COMMENT 3: 78.27(2)"d" Needs Assessment:** The respondent understands that the managed care organizations will be completing the needs assessments through the standardized assessment outlined in the Balancing Incentive program not the case manager or care coordinator.

**RESPONSE:** The Department will not be making any changes to the rule. The rules in item 52 references fee for service members. The mental health standardized assessment tool that was required of the Balancing Incentive Program has not yet been determined. Once the tool and process is determined, the rules will be changed.

**COMMENT 4: 78.27(2)"e" Plan for Service** The respondent recommended that the first sentence read: The department or the managed care organization Iowa Plan for Behavioral Health contractor has approved the member's comprehensive service plan for home- and community-based habilitation services.

**RESPONSE:** The Department will not be making a rule change. This rule change is in reference to fee for service members only. MCO requirements are found in chapter 73.

**COMMENT 5: 78.27(2)"e" Plan for Service** The respondent states that comprehensive treatment plan approval is a responsibility of the managed care organizations and they will not be using the ISIS management information system unless the individual is fee for service and not yet a member of a particular MCO.

**RESPONSE:** The Department will not be making any changes to the rule. This rule is for fee for service members.

**COMMENT 6: 78.27(4)"a"(9) Comprehensive Service or Treatment Plan** Respondent understands that this initial approval of and updates to the comprehensive service plan or treatment plan is a responsibility of the managed care organizations unless the individual is fee for service and not yet a member of a particular MCO.

**RESPONSE:** The Department will not be making a rule change. This rule change is in reference to fee for service members only. MCO requirements are found in chapter 73.

**COMMENT 7: 78.27(11) Adverse Service Actions** Respondent states that the managed care organizations have the ability to do these same adverse service actions but it takes out the references to them. Shouldn't they be included here for those who are members of the managed care organizations?

**RESPONSE:** The Department will not be making a rule change. The Iowa Administrative Code 441-73, the Managed Care Request for Proposal and the Managed Care Organization contract addresses the responsibilities of the MCO. Chapter 78 is for fee for service

**COMMENT:** Rule 441-78.28{8): Respondent proposes to use the following consistent description of services in all sections: "nursing, psychosocial, developmental therapies and personal care". Respondent also proposes to remove the "per discipline" language as providers currently indicate expected number of hours per day / days per week based on the plan of care using a combined hourly rate.

**RESPONSE:** The Department agrees with the comment and will be making the following changes:

**78.28(8) Nursing, ~~personal care, or psychosocial~~ psychosocial, developmental therapies and personal care services** provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate ~~per discipline~~.

**COMMENT: 78.33 Case Management Services** Respondent notes that the rule references "targeted case management", which will not continue after July 1, 2016 and should be noted in the rules. Also, references to "chronic mental illness" should be deleted as CMI members are managed through integrated health homes. Reference to "children's mental health waiver" should be deleted as there is no targeted case management for children's mental health waiver members.

**RESPONSE:** The Department will not be making a rule change. Community Based Case Management provided by current Targeted case managers (TCM) will continue until July 1, 2016 through the MCO and through fee for service. Rules regarding care coordination through TCM or Integrated Health Homes will be noticed in the future to address this issue.

### **78.57 Child Care Medical Services**

**COMMENT 1: 78.57(2)** The respondent recommends to add language to the end of the last sentence after self-help skills to include teaching pro-social skills and reinforcing positive

interactions. These are current program activities and this addition clarifies that these activities could be provided by a trained caregiver without licensed mental health oversight.

**RESPONSE:** The Department agrees with the comment and will be making the following changes:

**78.57(2)** Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(4). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching pro-social skills and reinforcing positive interactions.

**COMMENT 2: 78.57(3)** The respondent recommends striking the language "teach pro-social skills and reinforcing positive interactions," and replacing it with "focus at decreasing or eliminating maladaptive behaviors". This clarifies the type of care plan interventions that are truly "psychosocial services" and need the review of licensed mental health providers.

**RESPONSE:** The Department agrees with the comment and will be making the following changes:

**78.57(3)** Psychosocial services are those services that ~~teach pro-social skills and reinforce positive interactions~~ focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(4). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

**COMMENT 3: 78.57(3a):** Proposed new rule, the respondent stated that there are definitional paragraphs for nursing services, personal care services and psychosocial services but no definitional paragraph for developmental therapies and recommended a new paragraph to assist in clarifying developmental therapies that would be as follows:

"Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(4). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor and receptive expressive language."

**RESPONSE:** The Department agrees with the comment and will be making the following changes:

78.57(3) (A) Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(4). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individuals needs such as fine motor, gross motor, and receptive expressive language.

**COMMENT 4:** With regard to rule 441—78.57(5), the respondent proposed adding the term, “developmental therapies” throughout the rule and proposed that treatment plan language be deleted and “plan of care” be inserted in lieu thereof for consistency. The respondent also proposed changes to 78.57(5) “c” (8) to clarify information requirements.

**RESPONSE:** The Department agrees with the comments and will be making the following changes:

#### **78.57(5) Requirements.**

- a. Nursing, psychosocial, developmental therapies and personal care ~~Nursing, personal care, or psychosocial~~ services shall be ordered in writing.
- b. Nursing, psychosocial, developmental therapies and personal care ~~Nursing, personal care, or psychosocial~~ services shall be authorized by the department or the department’s designated review agent prior to payment.
- c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department’s designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department’s designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. ~~The treatment plan~~ plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:
  - (1) Place of service.
  - (2) Type of service to be rendered and the treatment modalities being used.
  - (3) Frequency of the services.
  - (4) Assistance devices to be used.
  - (5) Date on which services were initiated.
  - (6) Progress of member in response to treatment.
  - (7) Medical supplies to be furnished.
  - (8) Member’s medical condition as reflected by the following information, if applicable:
    1. Dates of prior hospitalization.
    2. Dates of prior surgery.
    3. Date last seen by a primary care provider.
    4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.

- 5. Prognosis.
  - 6. Functional limitations.
  - 7. Vital signs reading.
  - ~~8. Date of last episode of instability.~~
  - 89. Date of last episode of acute recurrence of illness or symptoms.
  - 940. Medications.
- (9) Discipline of the person providing the service.
- (10) Certification period.
- (11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.
- (12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.

**COMMENT:** The Department received two similar comments from respondents regarding 441—79.1(2). The respondent states that the current rates for non-state owned psychiatric medical institutions for children were established by Magellan as the contractor for the Iowa Plan for Behavioral Health and wants to clarify that the Effective 7/1/14 fee schedule is the current rates as in Attachment B.

The respondents wanted to clarify that the Fee schedule in effect on 7/1/13 is the current rates as in Attachment A for the Community BHIS and that the Residential BHIS will continue at the current per diem rate. Currently the billing code is H0019 and the residential BHIS per diem is \$78.16. The Foster Group Care (Child Welfare funding) and residential BHIS combination funding needs to continue to be “kept together” after the managed care transition in January.

**RESPONSE:** The Department will not be making any changes to the rule.  
The rates in effect are those that were in effect with Magellan, Iowa Plan for Behavioral Health contractor, as of 7/1/14.

**COMMENT: 79.1(8)** The respondent encourages the expansion of the source of AAC and WAC related information beyond listing one specific company in regulation to allow for multiple drug pricing companies to compete for Iowa's business. We would suggest opening the language by one of two options and referencing drug databases currently approved by and in use at the federal level, or else open the statute to reference other drug databases by proprietary name and submit following options for amendment to the proposed regulation where a reference to one company exists:

- Option 1: published by ~~Medi-Span~~ a nationally recognized provider of drug pricing shall
- Option 2: published by Medi-Span or the Elsevier Gold Standard Drug Database shall

**RESPONSE:** The Department will not be making any changes to the rule.  
The reference to Medi-Span as the drug pricing source used is not a change. The rules reference the particular source currently used for informational purposes and the rules can be changed if another source is used as the program's reference.

**COMMENT:** In sections 79.1(8) (a) and (b), the respondent request clarification of applicability to fee for service and/or managed care organizations. If applicable to managed care organizations, we request the rule recognize different pharmacy pricing allowed for multi-state chain and non-chain pharmacy providers in the contracts with managed care organizations.

Respondent also references the industry-standard lesser of pricing that includes a lesser of equation consisting of three parts: provider's submitted charge, U&C, or contracted rate and states that if this methodology is applicable to managed care organization claims, please confirm the methodology when no AAC or WAC price exists for the drug. Regarding subsection 79.1(8)(e), respondent requests clarification as to the applicability to managed care organizations and if applicable to managed care organizations, the language of this subsection, does not reflect the language in the contracts with managed care organizations that outlines different pharmacy pricing for multi-state chain and non-chain pharmacy providers

**RESPONSE:** The Department will not be making any changes to the rule.

Item 70, which amends 79.1(8), removes outdated references to average wholesale price (AWP) and state maximum allowable cost (SMAC) from the rules governing Medicaid fee-for-service drug reimbursement. As stated in the preamble to the proposed new chapter 73 on managed care (in ARC 2242C), program benefits provided through managed care will be paid for by managed care organizations participating in the program pursuant to payment rates or methodologies established by the managed care organization in their contracts with providers, consistent with chapter 73 and with the contracts between the Department and the managed care organizations, not pursuant to the rates and methodologies in chapter 79. Therefore the suggested change to the proposed amendments to 79.1(8) will not be made.

**Comment:** 81.1 Respondent request an updated definition for "rate determination letter". "Rate determination letter" means the letter that is distributed quarterly by the Iowa Medicaid Enterprise to each nursing facility and Managed Care Organization notifying the facility of the facility's Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

**RESPONSE:** The Department will not be making any changes to the rule.

This section is applicable to fee for service only. Rates for the MCO will be a contracted rate between the MCO and the provider.

**COMMENT:** 81.6(16)"g" Respondent requesting to strike the outdated Pay for Performance Program found in paragraph 441-81.6(16)"g".

**RESPONSE:** The Department will not be making any changes to the rule.

Pay for performance is still required in the Code of Iowa but has not been funded. Therefore, this section must remain in the event that funds are put towards this effort. If the Code of Iowa changes, this will be removed from the rules.

**COMMENT:** 81.6(16)"i" Respondent requesting to add provider rate protection language found in DAS's Request For Proposal for the Iowa High Quality Healthcare Initiative

**RESPONSE:** The Department will not be making any changes to the rule.

The requirements regarding how MCO's will pay are in the contract with the MCOs. All requirements of the MCOs are not included in rules but are in the RFP and the contract.

**COMMENT:** 81.6(21) Respondent requesting to include language for the Quality Assurance Assessment Fee to be paid by both DHS and the MCOs

**RESPONSE:** The Department will not be making any changes to the rule. The rules in Chapter 81 refer to fee for service only. The MCO requirements are in Chapter 73, the Request for Proposal and the MCO contract.

**COMMENT:** 81.13, the respondent proposed to amend rule 441—81.13(249A) as follows: 441—81.13(249A) Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program. The Managed Care Organizations shall give all enrolled nursing facilities meeting the conditions of participation for Medicaid the opportunity to be part of its provider network.

**RESPONSE:** The Department will not be making any changes to the rule. Currently, all long term care providers, including nursing facilities, are required to be offered a contract for the initial two years. After the initial period of implementation of managed care, the MCO will be responsible to determine which providers will be in their network. The Department will not dictate who must be in the MCO network after the initial implementation timeframe as explained above, but must assure network adequacy.

**COMMENT:** 81.13(3) (3) Respondent stated they would just request that DHS understand that many times in rural areas especially advanced registered nurse practitioners are primary care providers and they may be the ones that are writing the orders and from the proposed rules multiple places throughout the rules they reference only the physician. They would hope that if it's their intent that also ARNPs and PAs be allowed to do those things, that that be clarified more specifically in the rules.

**RESPONSE:** The Department will not be making any changes to the rule. The scope of practice for each discipline has not changed under the proposed rules. Therefore, current practice will continue for the work the ARNP's and PA's are able to do. This is dictated by state licensure of each discipline.

**COMMENT:** 82.2(4)“c”(2), Respondent states that the new language specifies that for those clients enrolled with a managed care organization the client's case manager shall participate as appropriate and as allowed by the client. Currently, ICF/ID clients do not have outside case managers. They are request clarification regarding the specific role and responsibility of the newly created case manager position as set forth in this proposed rule.

**RESPONSE:** The Department will not be making changes to this rule. Iowa has utilized the MFP transitional specialist to participate in the annual team meeting with ICF/ID residents to provide assistance with discharge planning, advocacy or overseeing quality of care. This activity will now transition to the MCOs.

**GENERAL COMMENTS:**

**COMMENT:** I would prefer that the current system remain in place.

**COMMENT:** We respectfully request that this process be delayed until such time adequate training and communication is provided by the Department as well as the MCO's.

**COMMENT:** So I'm very much opposed to the transition from publicly funded to privately funded/privately managed programs. I'm very concerned about what's going to happen to people who are assigned to Wellcare so that's why I'm here.

**COMMENT:** I am opposed to the managed care plan for one simple reason. It makes no sense to establish a new infrastructure to service Medicaid recipients with their benefits when the experienced staff of Department of Human Services is functioning well to deliver these services.

**RESPONSE:** The Department does not support the recommendations found within the general comments.