

Comments and Response on ARC 3476C and ARC 3602C
Medicaid Tiered Rates
Received October 11, 2017 – February 23, 2018

These amendments will change the rate setting methodology used to develop daily Supported Community Living (SCL), full day Day Habilitation, and full day Adult Day Care service rates in the Intellectual Disability Waiver. The SCL methodology will change from the current retrospectively limited prospective rate setting process to a fee schedule using a tiered rate methodology. Day Habilitation and Adult Day Care service rates are currently established through a fee schedule but will be changed to a fee schedule using tiered rates. The tiered rate methodology establishes a tiered system of reimbursement based on the identified acuity level from the results of the Supports Intensity Scale ® (SIS) core standardized assessment.

The move to tiered rates will be cost-neutral to the Department. The tiered rate funding methodology will assign a standardized service rate based on member need rather than the current methodology of services reimbursement based on provider costs. With this rule change, some providers will see increased revenues compared to current service reimbursement for the members currently served and other providers will see decreased revenues.

These amendments were adopted and filed through emergency rulemaking and became effective December 1, 2017. These amendments were also published in the Iowa Administrative Bulletin for the purpose of receiving comments from the public. The Department received public comments from October 11 through November 10, 2017. From these initial comments, the Department received a number of requests for public hearing on these amendments resulting in two public hearings held in February 2018.

The following persons and organizations provided written comments, which are included in the summary below:

Reed Beatse	Katie Cummins	Lisa Pakkebier	Rachael Cox
Alyson Beytin	Carol Hess	Megan Popenhagen	Libra Edmundson
Adam McLaughlin	Stacie Lane-O'Brien,	Justina Stodola	Patricia Lane
Marie Hafner	Becki Reiff	Carol Ebinger	Khine McGowan
Teresa Tibbott	Douglas Nye	Stephanie Kuennen	Laurie Cummins
Phil White	Nancy Whitaker	Sue E. Lewis	Theresa Phillips
Casey Westhoff	Peggy Dietrich	Thomas Davis	Jennifer Hahn
Jen Simmering	Mary Jo Scott	Kathy and Tom Lynch	Kathy Keasler

Linda Dunshee	Kim Birr	Cathy Larson	Matt Green
Stephanie Kuennen	Sam Bunkers	Cynthia Jewell	Terri Reynolds
Marilyn Althoff	Lea Davis	shawn Corkery	Josh Wilson
Steve Pearson	Dale Rettenmeier	Christina Harper	Joshua Super
Chad Pence	Carol Powers	Kris Eastman	James Schroeder
Tracie Brown	Marie Krebs	Joni Houck	Fritha Coltrain
Julia Feltes	Adam Grosso	Zita Cashin	Jacob Clark
Barbara Mallaro	Laura Jackson	Nancy Stalzer	Mallory Moore
Melissa Cloud	Brandon Ludwig	LeRoy Smith	Adam Yack
Stacie Lane-O'Brien	Josh Super	Judy Bannon	Jade Stiles
Chuck Blackhurst	Rebecca Spence	Lisa Schwanke	Brian Abbott
Michele Morgan	Linda Dunshee,	Jeff Vance	Rachael Miller
Katie Marine	Bob Bartles	Jolene Sorenson	Lisa Bernhard
Janet Outlund	Patrick Costigan	Connie Haneline	Sherry A Horan
Michelle Lloyd	Liz Armentrout	Adam McLaughlin	Justina Stodola
Cantor Gail & Rabbi Henry Karp	Anthony Gómez-Reynolds	Dianne Schlesselman & Robert	

Based on comments from the October 11 - November 10, 2017 public comments, public hearings were scheduled in Coralville, Iowa on February 21, and Dubuque, Iowa on February 23, 2018. The following gave public comment or were in attendance:

Coralville IA February 21, 2018	Dubuque IA February 23, 2018
Made Comments:	
Jim Fox	Alison Beytien
Stacie Lane-O'Brien	Bill Stumpf
Roger Lusala	Marilyn Althoff

Nathaniel Pierson	Rebecca Spence
Sandy Hamm	Teresa Tibbott
Delaine Peterson	Katherine Toops
Ann Brownsberger	Kelly Heysinger
Craig Harwood	Cody Brickman
Christine Gloser	Michelle Schmitt
Ann Harris	Gill Spence
Leah Donald	
Jim Gorm	
In attendance, did not comment	In attendance, did not comment
Terri Bronner	Diane Kalmes
	Kara Bahl
	Rick Ball
	Steve Horap
	Mary Jacobs
	Bryan Main
	Crystal Dole
	Jill Meirds
	Marty C.
	Sarah Seifert
	Michelle Schmitt

A. Summary of submitted comments October 11, 2017 – November 10, 2107

Comment A-1. Comments were received from twenty-one respondents that included the following language or a minor variation of this comment:

I'd like to express my grave concern about the timeline for implementation of tiered rates for ID Waiver population. Fewer than thirty days is not enough time for members, families and providers to adjust service plans and business models to deal with these changes, especially in light of the end of the AmeriHealth Caritas contract, which will place additional administrative burden on agencies at the same time as the tiered rate implementation.

I would request, along with others, a public hearing on this matter

Department response A-1: Public hearing was held February 21, 2018, in Coralville and February 23, 2018 in Dubuque. See summary of comments below.

Comment A-2. Comments were received by Twenty-four respondents that specifically asked that public hearings be held throughout the state to allow for comments from members, guardians, providers, and advocates be heard.

Department response A-2: Public hearing was held February 21, 2018, in Coralville and February 23, 2018 in Dubuque. See summary of comments below.

Comment A-3. Comments from eleven respondents address the perceived negative impact that tiered rates would have on services received because of lower service reimbursement rates.

Department response A-3: Tiered reimbursement rates are designed to assign a standardized rate reimbursement paid to provider agencies for services rendered based on the severity of a member's disability and the intensity of a member's needs as assessed through a core standardized assessment tool. Tiered reimbursement rates provide funding for services to members based on the severity of the member's needs rather than the allowable provider costs that have driven reimbursement rates in the past. Reimbursement is higher for members with more severe needs and lower for those that present relatively less severe needs as documented by the SIS assessment. The tiered rate funding methodology will fairly and consistently reimburse providers based on the assessed member's needs. Thus, tiered rates result more particularized reimbursement rates for each ID Waiver participant. Most providers across the state will see an increase or will maintain current levels of funding for services.

Comment A-4. Comments from Twelve respondents expressed concerns with the use of the Supports Intensity Scale ® (SIS) to either determine a funding tier for the member or that families and providers had limited understanding of the SIS or access to the SIS scores.

Department response A-4: The SIS, published by the American Association on Intellectual and Developmental Disabilities ("AAIDD"), is a core standardized assessment that is used nationally to assess the support needs of persons with intellectual disabilities. The SIS has also been used as a tool to assist funders with resource allocation as a way to reimburse service providers rates based on member service needs. At least thirty-three (33) states have used the SIS tool and eight (8) have used the SIS in combination with resource allocation to reform service delivery.

Comment A-5. Twenty-five respondents addressed comments regarding the short notification time period to providers for the rate changes. Respondents stated that a 30 day notice of rate changes was not enough time for providers to adjust their business practices. It was requested to delay the implementation of tiered rates and not go into effect on December 1, 2017.

Department response A-5: Tiered rates will be phased in over a 19 month time period to allow providers to adjust their business practices to the new rates. SCL providers will not have more than a two percent reduction in revenues in for the first 7 months, then no more than 13 percent reduction for the following 12 months, July 1, 2018 to June 30 2019. Full tiered rate fee schedules will go into effect for all providers July 1, 2019. The Department did not delay the December 1, 2017, effective date of implementation of the tiered rates.

Comment A-6. Twenty-two respondents stated that the exit of AmeriHealth Caritas as one of the MCOs within the state on December 1, 2017, complicates the move to implementing tiered rates and could cause disruption in services provided and payment to providers.

Department response A-6: With the withdrawal of AmeriHealth Caritas from managed care in Iowa, the Department has worked and is continuing to work to make a seamless transition of members from AmeriHealth to reduce the impact to services to members.

Comment A-7. Nine respondents addressed opposition of the inclusion of transportation in the SCL rate. Comments include:

- Why the inclusion of transportation in the SCL service was not discussed with the provider stakeholder group.
- Providers did not have enough time to set up and pay for transportation starting 12/1/17.
- Transportation costs that were put into SCL rates are not enough to cover all transportation costs of individual members
- Members will lose critical transportation to keep them connected to community resources.

Department response A-7: The decision to include reimbursement for all transportation into the daily SCL rate was made by the Department to give flexibility to providers to coordinate and manage transportation to meet the needs of the members they serve. When tiered rates were developed, the cost of all transportation of members accessing daily SCL was identified and incorporated into the final tiered rates. This includes approximately \$3M that was included by providers as part of the funds in the daily SCL rates as well as approximately \$10M in waiver transportation service costs associated with members receiving daily SCL services. There was not a reduction in the amount of funding available for transportation, but rather a different way of distributing the costs to providers of daily SCL services.

B. Other written comments that were received October 11 - November 10, 2017 from three or fewer commenters:

Comment B-1. I want to thank the Department for moving to the new funding methodology. The outdated “cost based” system rewarded providers who had the resources to spend up, thus increasing their rates over time. Further, it was too complicated, with every provider having a unique and different rate. The tiered rate system is much more fair, with every provider getting equal reimbursement based on the tier levels of persons served.

Department response B-11: Thanks for the supportive comment

Comment B-2. It does not make sense to group individuals into categories for the purpose of funding – they are individuals.

Department response B-2: The Department believes the tiered rate funding methodology will fairly and consistently reimburse providers based on the assessed member’s needs. In addition, tiered rates provide a more individualized reimbursement methodology.

Comment B-3. Did the Department use any geographic or regional wage/employment data etc. in the process as outlined in the CMS guidance for rate setting process?

Department response B-3: The use of geographic or regional wage/employment data for tiered rate setting was discussed internally by the Department. The Department has never previously used regional wage/employment data when determining HCBS waiver service rates. Because this could set costly precedent, the Department determined that the use of regional data would not reflect the best allocation of resources in this context

Comment B-4. The IME did not sufficiently address or partner with providers of services to people with significant behavioral challenges.

Department response B-4: The Department recruited a provider stakeholder group with the assistance of the Iowa Association of Community Providers (IACP) for input into the development of the tiered rate methodology. The selected stakeholders represent providers that serve a wide range of members’ needs and abilities.

Comment B-5. I have been told that Money Follows the Person (MFP) rates were not included in the tier process.

Department response B-5: Correct. Only rates from members accessing the ID waiver program were used in the tiered rate methodology. This includes members that had transitioned from the MFP program to the ID waiver after MFP funding ended

Comment B-6. The legislators may have made a hasty decision to implement tiered rates.

Department response B-6: Thank you for your comment.

C. Summary of comments received from public hearings held February 21, 2018, in Coralville and February 23, 2018 in Dubuque.

Comment C-1. Providers were not notified in a timely manner of the rate changes that became effective 12/1/17. Providers do not have the ability to react quickly even within 18 short months to that significant of a revenue reduction.

Department response C-1: Tiered rates will be phased in over a 19 month time period to allow providers to adjust their business practices to the new rates. SCL providers will not have more than a two percent reduction in revenues in for the first 7 months, then no more than 13 percent reduction for the following 12 months, July 1, 2018 to June 30 2019. Full tiered rate fee schedules will go into effect for all providers July 1. 2019. The Department did not delay the December 1, 2017, effective date of implementation of the tiered rates.

Comment C-2. Many providers had a significant revenue loss for day habilitation starting 12/1/18. Some as high as 50%. Why were the tiered rates for day habilitation and adult day care services not phased in like the SCL daily rates were?

Department response C-2: The Department worked with the provider stakeholder group in the rate development process. Based on stakeholder input, phase-in rates for day habilitation and adult day services were deemed unnecessary

Comment C-3. The SIS tool:

- Sections of the SIS were not used to determine rates. We contend that the instrument loses all validity and reliability at this point and the resulting tier assignments are negatively impacted
- If the individuals who apply the SIS assessment are the employees of the insurance company, how can we trust that the scoring will be fair and unbiased and there is a lack of due process for appeals.
- Owners of the SIS assessment, experts nationally in the field of individuals with developmental disabilities and ID services and providers would agree that this SIS should not be solely used as a primary source of resource allocation. In our opinion, Iowa did not investigate and/or listen to the suggestions of national experts that indicate the SIS should not be the primary source of resource allocation for people with individual disabilities.
- I have concerns like other people have stated about the SIS assessment that it was not transparent as to how the results of that assessment were going to be used. That the individuals administering the assessment maybe don't understand how it's supposed to be administered or people giving input don't understand how the information is going to be used as a result so some concerns about the SIS assessment
- The SIS is not objective as someone mentioned earlier it leaves out a lot of the important parts, the assessment we used to do was comprehensive.

Department response C-3: The SIS assessment is a valid and reliable tool that has been used to determine member level of care in the ID Waiver in Iowa since 2013. Per the American Association of Intellectual and Developmental Disabilities (AAIDD), the developer and owner of the SIS, a full SIS assessment may be completed every three to five years, with annual reviews of the SIS information, and still remains accurate and reliable. Iowa has chosen to complete a full SIS assessment every three years with an off year assessment completed annually to assure members continue to meet the ID Waiver level of care. If there is a significant change in a member's needs in the years between the full SIS assessments, a guardian or provider may request to have a full SIS completed.

SIS assessments are completed by a neutral entity trained in the SIS assessment review process. Completion of the SIS assessment is the responsibility of the state for the Fee-for-Service (FFS) population and the MCOs for members receiving managed care. The SIS assessor follows a quality plan to ensure the SIS is administered and scored in a manner consistent with the American Association of Intellectual and Developmental Disability (AAIDD) standards. SIS assessors complete multiple quality assurance activities to assure that all assessments are valid and reliable. This includes an Interviewer Reliability and Qualifications Review (IRQR) at a minimum of two times per year with an AAIDD certified assessor. Through the various internal QA processes conducted on the assessors and the assessment process, the SIS assessment is considered reliable, which means the results obtained are consistent with the results obtained by the SIS authors, plus or minus an acceptable error rate. Since 2004, at least thirty-three (33) states have used the SIS tool and eight (8) have used SIS in combination with resource allocation to reform service delivery.

Based on the above, the Department believes the SIS is an appropriate tool for the development of tiered rates.

Comment C-4. The tiered rate work group was established by DHS and IME, but it was not a well-functioning group. This is reflected by not meeting for a period of February through October.

Department response C-4: Thank you for your comment. As mentioned above, the Department recruited a provider stakeholder group with the assistance of the Iowa Association of Community Providers (IACP) for input into the development of the tiered rate methodology. The selected stakeholders represent providers that serve a wide range of members' needs and abilities. The Department valued the information and input from the stakeholder group and used the input in the development of the tiered rates.

Comment C-5. Suggestions for change to the rules:

- Allow day program providers the same phased-in approach as the others were given.

Department response C-5: The Department worked with the provider stakeholder group in the rate development process. Based on stakeholder input, phase-in rates for day habilitation and adult day services were deemed unnecessary.

Comment C-6. The SIS instrument and resulting tier assignment needs to be administered by an independent entity that uses the entire instrument as it was designed.

Department response C-6: As noted above, the SIS is administered by an independent entity and the assessors complete the full SIS assessment with the member based on AAIDD standards. The member tier assignment is determined by an IME or MCO entity that are separate from the SIS assessors and uses relevant, but not all, information from the SIS to determine rates. The SIS assessors only conduct and score the SIS assessment. The scores from the SIS assessment are used by the separate entity. SIS information regarding employment and self-advocacy are not used to determine tiered rates. SIS information regarding employment (SIS section 2D) and life-long learning (SIS section 2C) are not used to determine tiered rates.

Comment C-7. There needs to be due process appeals procedure for challenges and/or tier assignment with time limited considerations and an administrative judge to be the final arbitrator.

Department response C-7: The member tier assignment is based on the final results of the SIS assessment. Processes are in place that allows input and resolution when there are disagreements with the outcome and scoring of the SIS assessment. A member's tier assignment is based on the final results of the SIS assessment and, as such, there is no adverse action taken by the Department when making tier assignments. That being said, the Department will amend the published rules to remove the language concerning tiered rate appeal rights.

Comment C-8. Terminate the contract for the managed care.

Department response C-8: Thank you for your comment.

Comment C-9. Remove transportation payments to and from day habilitation and adult daycare from the requirements for daily SCL providers.

Department response C-9: The decision to include reimbursement for all transportation into the daily SCL rate was made by the Department to give flexibility to providers to coordinate and manage transportation to meet the needs of the members they serve. The Department continues to support this decision in pursuit of that goal.

Comment C-10. Reestablish previous rates of service to providers of people within Tier 5 and 6 and move these people to services through Managed Care to the State of Iowa.

Department response C-10: The Department does not support the separation and mixing of rate setting methodologies within a scope of services. Individual rates for members outside of the tiered rate payment may be made through exception to policy

for fee-for-service members or single case agreements with MCOs. Any significant change in the managed care contract as suggested will require the actions of the Iowa Legislature and the Governor.

Comment C-11. Establish a specific worker to focus on high need individuals for people with intellectual disabilities with leadership provided by Iowa Medicaid.

Department response C-11: Thank you for your comment.

Comment C-12. Remove the SIS assessment from United.

Department response C-12: SIS assessments are completed by a neutral entity trained in the SIS assessment review process. This applies to MCOs as well as the IME. The Department believes there are appropriate firewalls to assure the SIS assessments are both valid and reliable as currently in place.

D. Specific rule comments and recommendations:

The Department received comments to specific proposed tiered rate rules from three respondent organizations

Specifically:

Amend paragraph **78.41(1)**“f,” introductory paragraph, as follows:

f. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members’ specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager’s service plan, ~~the total costs shall not exceed \$1570 per member per year,~~ and the provider must maintain records to support the expenditures. A unit of service is:

Comment D-1: Two respondents stated that since paragraph 78.41(1)“f” pertains only to supported community living services in the intellectual disability waiver, it should be stricken in its entirety. The provider budgets, costs and records to support expenditures referenced in paragraph “f” are no longer relevant in a tiered rate payment system that relies solely on the client assessment to determine payment levels.

The respondents also recommend that 78.41(1) supported community living be amended to add that remote monitoring be an allowable service as ordered and directed by an interdisciplinary team and specify that it is not considered a day service for the purpose of tier determination.

Department response D-1: The Department partially agrees with this comment. The Department will remove rule language concerning staff-to-member ratios but will retain rule language to support the need for budgets and the need for supports to be identified

in a case manager's service plan. See final rule modification at the end of this summary.

Amend subrule 78.41(11) as follows:

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed ~~simultaneously with~~ when HCBS intellectual disability waiver daily supported community living service ~~when the transportation costs are included within the supported community living reimbursement rate is authorized in a member's service plan.~~

Comment D-2: One respondent opposed the proposed rule. Prior to the rule, there was flexibility in the provision of transportation to Medicaid members in daily supported community living and tailored to meet the needs of a wide variety of members on the ID waiver. This change is more restrictive, limiting, and less flexible in how people can access transportation to meet their needs. It is also significantly underfunded in relation to resources available prior to the change, putting the financial wellness of providers in significant jeopardy.

The respondent also believed the proposed change is contrary to the federal settings rule in that it will force the use of congregate transportation as SCL providers are not allocated sufficient resources and are forced to consider the most cost-efficient means of meeting member transportation needs. The unintended consequence is forcing members to rely more heavily on SCL providers for transportation instead of other existing community-based providers, which may be better suited depending on the situation. In essence, this is a one size fits all mode instead of one with flexibility that can accommodate the varying needs of Medicaid members.

Department response D-2: The decision to include reimbursement for all transportation into the daily SCL rate was made by the Department to give flexibility to providers to coordinate and manage transportation to meet the needs of the members they serve. When tiered rates were developed, the cost of all transportation of members accessing daily SCL was identified and incorporated into the final tiered rates. This includes approximately \$3M that was included by providers as part of the funds in the daily SCL rates as well as approximately \$10M in waiver transportation service costs associated with members receiving daily SCL services. There was not a reduction in the amount of funding available for transportation, but rather a different way of distributing the costs to providers of daily SCL services.

Providers have options when managing transportation. A SCL provider may continue to provide transportation to members as they have in the past. They may also decide to start providing transportation or increase the amount of transportation they currently provide. A provider may also continue to coordinate the use of existing HCBS waiver service transportation providers, like community-based transportation (bus, taxi, Uber, Regional Transit Authorities, etc.) available in their area of the state. The SCL provider

is tasked with managing a finite amount of transportation funding available to the members they serve. The difference now will be that the SCL provider is responsible for the payment of these transportation options. In all situations, the member should have access to the transportation to meet their needs.

79.1(29) Tiered rates. For supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the Intellectual Disabilities Waiver, the fee schedule published by the Department pursuant to 441-79.1(1)“c” provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

a. Acuity tiers are based on the results of the Supports Intensity Scale® (SIS) core standardized assessment. The SIS assessment tool and scoring criteria are available on request from the Iowa Medicaid Enterprise, Bureau of Long Term Care.

b. The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the SIS scores.

c. For Supported Community Living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services an member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

- (1) Members who receive an average of 40 hours or more of day services per month.
- (2) Members who receive an average of less than 40 hours of day services per month.

d. For this purpose, the “SIS activities score” is the sum total of scores on the following subsections:

- (1) Subsection 2A: Home Living Activities;
- (2) Subsection 2B: Community Living Activities;
- (3) Subsection 2E: Health and Safety Activities; and
- (4) Subsection 2F: Social Activities.

e. Also used in determining a member’s acuity tier, as provided in paragraphs “f” and “g,” are the subtotal scores on the following subsections:

- (1) Subsection 1A: Exceptional Medical Support Needs, excluding questions 16 - 19; and
- (2) Subsection 1B: Exceptional Behavioral Support Needs, excluding question 13.

f. Subject to adjustment pursuant to paragraph “g,” acuity tiers are the highest applicable tier pursuant to the following:

- (1) Tier 1: SIS activities score of 0 – 25.
- (2) Tier 2: SIS activities score of 26 -40.
- (3) Tier 3: SIS activities score of 41 – 44 or SIS activities score of 0-40 and a SIS subsection 1B subtotal score of 6 or higher.
- (4) Tier 4: SIS activities score of 45 or higher.

(5) Tier 5: SIS activities score of 41 or higher and a subsection 1B subtotal score of 7 or higher.

(6) Tier 6: SIS subsection 1A or 1B subtotal score of 14 or higher.

(7) RCF Tier: Members residing in a residential care facility (RCF) licensed for six or more beds.

(8) RBSCCL Tier: Members residing in a residential based supported community living facility.

(9) Enhanced Tier: An individual member rate negotiated between the Department and the provider.

g. The tier determined pursuant to paragraph “f.” shall be adjusted as follows:

(1) For members with a subsection 1A subtotal score of 2-3, as provided in subparagraph “e”(1), but with a response of “Extensive Support Needed” (score = 2) in response to any prompt in subsection 1A, as provided in subparagraph “e”(1) and an otherwise applicable tier of 1-4 pursuant to paragraph “f,” the tier is increased by one tier.

(2) For members with a subsection 1A subtotal score of 4-9, and an otherwise applicable tier of 1-4 pursuant to paragraph “f,” the tier is increased by one tier.

(3) For members with a subsection 1A subtotal score of 10-13, and an otherwise applicable tier of 1-3 pursuant to paragraph “f,” the tier is increased by two tiers.

(4) For members with a subsection 1A subtotal score of 10-13, and an otherwise applicable tier of 4 pursuant to paragraph “f,” the tier is increased by one tier.

(5) Any member may receive an enhanced tier rate when approved by the Department for fee for service members.

h. Tier redetermination. A member’s acuity tier may be changed in the following circumstances:

(1) There is a change in the member’s SIS activity scores as determined in the annual level of care redetermination process pursuant to Iowa Administrative Code 441-83.64(249A).

(2) A completed Emergency Needs Assessment, DHS Form 470-5486, indicates a change in the member’s support needs. A member’s case manager may request an Emergency Needs Assessment when a significant change in the member’s needs is identified. When a completed Emergency Needs Assessment indicates significant changes that are likely to continue in three of the five domains assessed, a full SIS core standardized assessment shall be conducted and any change in the SIS scores will be used to determine the member’s acuity tier.

(3) A member’s acuity tier assignment does not affect the services that the member will receive and is not considered an adverse action and therefore there are no appeal rights.

i. *New providers, provider acquisitions, mergers and change in ownership.* Any change in provider enrollment status including, but not limited to, new providers, enrolled providers merging into one or more consolidated provider entities, acquisition or takeover of existing HCBS providers, or change in the majority ownership of a provider on or after December 1, 2017, shall require the new provider entity to use the tiered rate fee schedule in accordance with 441—79.1(1)c.

Comment D-3: One responded recommended the following be incorporated into the new rule subsection 79.1(3):

“1. We presume that the rule applies both to managed care and Fee-for-service. This rule does not clearly state this and we request that it be amended to do so.”

Department response D-3: The IAC rules do not need to specifically identify each IAC rule that applies to MCOs. The MCOs have worked with the Department in the tiered rate methodology development and have agreed to use the tiered rates for provider reimbursement.

Comment D-4. Paragraph h.(3) states : A member's acuity tier assignment does not affect the services that the member will receive and is not considered an adverse action and therefore there are no appeal rights. One respondent strongly disagrees and requests that the paragraph be completely stricken and be replaced with: “A member and/or their representatives' disagreement with a tier assignment shall be considered an adverse action determination and therefore subject to appeal and all due process rights associated with the appeal process.”

Department response D-4: The member tier assignment is based on the final results of the SIS assessment. Processes are in place that allows input and resolution when there are disagreements with the outcome and scoring of the SIS assessment. A member's tier assignment, and the associated tier reimbursement rate, is based on the final results of the SIS assessment and, as such, there is no adverse actions taken by the Department when making tier assignments. That being said, the Department will amend the published rules to remove the language concerning tiered rate appeal rights.

Comment D-5. One respondent recommended that paragraph *h.* be amended to add and specify that a new and complete SIS assessments shall be done every three years and an off-year update be done annually (this follows current protocol). Either of which indicating a change in tier assignment is appropriate, shall result in such change effective upon completion of the assessment or update.

Department response D-5: The Department believes that paragraph *h.*, as written, best identifies that a tier assignment can change through the annual level of care redetermination process.

Comment D-6. There are many issue surrounding SIS assessments: The respondent stated that their agency currently does not have SIS assessments on approximately 33 members after multiple requests. The respondent has not received tier assignments for 9 of the members they serve. This is an issue that was known as evidenced by AmeriHealth Caritas FAQ regarding the tier transition (see Amerihealth update email at end of this document). Due to these issues, the respondent suggested the following changes to Item 7:

ITEM 7. Adopt the following new paragraph 83.67(4)“i”:

i. For members receiving daily supported community living, day habilitation or adult day care: the following scores from the ~~most recently completed~~ *current (within the last 3 years)* SIS assessment:

(1) Score on subsection 1A: Exceptional Medical Support Needs.

(2) Score on subsection 1B: Exceptional Behavioral Support Needs.

(3) Sum total of scores on the following subsections:

1. Subsection 2A: Home Living Activities;

2. Subsection 2B: Community Living Activities;

3. Subsection 2E: Health and Safety Activities; and

4. Subsection 2F: Social Activities.

Members who do not have a current SIS assessment will be assigned Tier 6 until a current SIS is completed.

Department response D-6: The Department believes the rule, as written appropriately addresses the timeline for completion of the SIS assessment.

E. HCBS ID Waiver Tiered Rate Public Comment Summary

The Department received comments on the proposed service funding change to a tiered rate methodology for SCL, Day Habilitation, and Adult Day Services. Responses were received from family members, providers and advocates. All public comments were received on or after October 11, 2017, through February 23, 2018. Most comments received expressed concerns on the fiscal impact to providers or the services received by their family member. One comment was received in support of the tiered rate methodology.

ANALYSIS AND ACTIONS TAKEN

The 2017 Iowa Legislature directed the Department to use tiered rates as a payment methodology in Iowa House File 653 (HF 653), section 93. The Department has been working to develop a tiered rate methodology with provider stakeholder and Managed Care Organization involvement since December 2016. Providers have had opportunity for input into the development and implementation of tiered rates through the stakeholder group and the public notice of the ID Waiver proposed amendment. Many of the stakeholder group recommendations were incorporated into the final tier rate development.

The Department has projected that Daily SCL tiered fee schedule rates will affect provider revenues in three ways: reductions, increases or relative neutrality. As a result, a transitional phase-in plan has been established as described below:

- Some providers will experience overall revenue reductions. Daily SCL tiered rate reimbursement for these providers will be higher than the final established tiered rates during the phase-in time period.

- Some providers will experience revenue increases. Daily SCL tiered rate reimbursement for these providers will be lower than the final established tiered rates during the phase-in time period.
- Some providers will have moderate revenue losses or gains. Daily SCL tiered rate reimbursement will begin at the tiered rates fee schedule on December 1, 2017.

Implementation of tiered rates for Day Habilitation and Adult Day Care services will use the tiered rate fee schedule beginning December 1, 2017. Tiered rate reimbursement for Daily SCL will be phased in over 19 months beginning December 1, 2017, with the use of the tiered rate fee schedule effective July 1, 2019. Providers who experience overall revenue reductions or increases will have the individual provider phase-in rates during the 19 month phase-in time period to give providers time to adjust their business practices to the new reimbursement rates. Individual provider phase in tiered rates have been sent to the identified providers by the IME.

The Supports Intensity Scale ® (SIS) assessment is a nationally recognized valid and reliable assessment tool developed and owned by the American Association on Intellectual and Developmental Disabilities (AAIDD). In addition to its use by a case manager in the development of the member's service plan, the SIS may be used to assign resource allocation based on the acuity level of a member. The SIS assessments are conducted by an entity trained in the use of the SIS that is independent from the Department and MCOs. The validity and reliability of the SIS assessment tool is maintained by AAIDD. The SIS has been used with the Iowa ID Waiver population for over four years. The SIS assessors conduct the assessment but do not determine the tier assignment. The tier assignment does not change the member's needs or service plan activities but does determine the reimbursement amount available to the provider to bill for services provided to the member. The tiered rates were developed based historical costs of providing services attributed to members within each tier.

Transportation has been incorporated into the reimbursement rates for daily SCL service. All transportation costs attributed to daily SCL members was added into the tiered rates. Non-emergency medical transportation (NEMT) will continue to be paid separately and is not a requirement for payment through the daily SCL rate.

The Department received many comments from family, guardians, advocates, and providers during the written and public hearing time periods. The majority of the comments did not make reference to the specific rules, but rather the impact the rules will have on funding for services. A list of all comments received is posted with this summary response

There were limited suggestions for changes to the tiered rate rules as currently published in the Iowa Administrative Code.

Based on the comments received from the public, the following changes will be made to the ID Waiver amendment:

ITEM 1. Amend **78.41(1)**“f as follows:

f. Provider budgets shall ~~reflect all staff-to-member ratios and shall~~ reflect costs associated with members’ specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager’s service plan, and the provider must maintain records to support the expenditures. A unit of service is:

Item 2. Amend 441.79.1(30)h.(3) as follows:

~~(3) A member’s acuity tier assignment does not affect the services that the member will receive and is not considered an adverse action and therefore there are no appeal rights.~~

The following five changes will be made to correct omissions or clarify the published rules as identified by the Department during the public comments:

Item 1. amend 441-78.41(12) as follows:

78.41(12) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), or a full day (4.25 to 8 12 hours per day); ~~or an extended day (8.25 to 12 hours per day)~~. Components of the service include health-related care, social services, and other related support services.

Item 2. amend 441-79.1(2) as follows

18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)	For intellectual disability and brain injury waiver effective 7/1/16: \$9.28 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3.927%.
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For intellectual disability waiver: Fee schedule for the member’s acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for

For intellectual disability waiver effective 7/1/17: \$9.28 per 15-minute unit. For daily service, the fee schedule rate published on the department’s website,

SCL-15 Minute See
79.1(15)

pursuant to 79.1(1)“c,” for the member’s acuity tier, determined pursuant to 79.1(30).

Item 3. amend 441 – 79.1(15) as follows:

79.1(15) HCBS retrospectively limited prospective rates. This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS intellectual disability wavier supported community living for 15-minute services; HCBS family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

Item 4. amend 441-79.1(30)d. as follows

d. For this purpose, the “SIS activities score” is the sum total of the subscale raw SIS scores converted to standard scores on the following subsections:

- (1) Subsection 2A: Home Living Activities;
- (2) Subsection 2B: Community Living Activities;
- (3) Subsection 2E: Health and Safety Activities; and
- (4) Subsection 2F: Social Activities

Item 5. amend 83.67(4)“i” as follows:

i. For members receiving daily supported community living, day habilitation or adult day care: the following standard scores from the most recently completed Supports Intensity Scale ® (SIS) assessment:

- (1) Score on subsection 1A: Exceptional Medical Support Needs.
- (2) Score on subsection 1B: Exceptional Behavioral Support Needs
- (3) Sum total of standard scores on the following subsections:
 1. Subsection 2A: Home Living Activities;
 2. Subsection 2B: Community Living Activities;
 3. Subsection 2E: Health and Safety Activities; and
 4. Subsection 2F: Social Activities.