

December 31, 2019

DHS Council Members:

Enclosed please find the materials for the January 8, 2020 meeting.

This meeting will be held by **Conference Call** - please see the agenda for the call-in information.

Please be sure to let me know if you will be unable to attend as a quorum is necessary.

Thank you,



Annie Lukens
DHS Council Secretary
515-281-5455

AGENDA**Wednesday, January 8, 2020****Time: 10:00 a.m. – 11:00 a.m.**

Hoover State Office Building

Director's Cabinet Room

1305 E. Walnut Street

Des Moines, IA

Dial: 1-866-685-1580**Code: 515-281-7064#****CONFERENCE CALL MEETING**

- 10:00 a.m. Call to order
- 10:05 a.m. Approval of Minutes – **December 11, 2019**
- 10:10 a.m. Counsel Action - Vote to create two Division Administrator positions to oversee MHDS; one for Community and the other for Facilities.
- 10:15 a.m. Rules - **Nancy Freudenberg**

The following amendments to the administrative rules are presented for adoption at the January 8, 2020, meeting of the Council on Human Services:

R-1. Amendments to Chapter 75, "Conditions of Eligibility." This rule will continue to allow an annual change in the statewide monthly standard deduction for personal care services provided in a licensed Residential Care Facility (RCF) based on the Consumer Price Index (CPI) for urban consumers. This annual change continues to be a benefit to Medically Needy members who reside in a licensed RCF because it allows the personal care needs to be applied to the spenddown obligation.

R-2. Amendments to Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and to Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care." This rulemaking updates and clarifies language to reflect existing prescribed outpatient drug policies for qualified prescribers, reasons for nonpayment of drugs, covered nonprescription drugs, quantity prescribed, drug reimbursement methodology and credits for returned unit dose drugs not consumed.

R-3. Amendments to Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Chapter 83, "Medicaid Waiver Services," and rescinds and adopts new Chapter 90, "Case Management Services". Clarifies the case

management service activities that are received by various populations in the Medicaid program. Revises rules to include definition and references to Core Standardized Assessments (CSA) as required under the Balancing Incentive Program (BIPP). The BIPP was created as part of the federal Patient Protection and Affordable Care Act. Participation by Iowa is required by 2012 Iowa Acts, chapter 1133, section 14, and 2013 Iowa Senate File 446, section 142 (20). Adds a section to outline and require billable activities for fee for service members. Adds a requirement for provider reporting of minor incidents. Adds the person-centered service planning definition and service requirements. Updates case management cross references in other chapters that are affected by this rule package.

R-4. Amendments to Chapter 81, “Nursing Facilities.” The department has promulgated rules in order to provide clarification on the treatment of depreciation when a change of nursing facility ownership occurs. Rules are also promulgated to clarify leasing arrangements. The department has updated the Iowa Medicaid Enterprise (IME) mailing address and made changes to reflect current operations of the IME.

R-5. Amendments to Chapter 95, “Collections.” This rule eliminates references to the application fee paid by non-assistance customers when requesting services from the Child Support Recovery Unit (CSU). Recent legislative changes to Iowa Code Chapter 252B.4 eliminated the customer paid fee. SF 605 also increased the annual fee for non-assistance child support cases.

- 10:30 a.m. Council Update
- 10:40 a.m. Director’s Report – **Director Kelly Garcia**
- 11:00 a.m. Adjourn

This meeting is accessible to persons with disabilities. (If you have special needs, please contact the Department of Human Services (515) 281-5455 two days prior to the meeting.)
Note: Times listed on agenda for specific items are approximate and may vary depending on the length of discussion for preceding items. Please plan accordingly.

**Meeting Minutes
December 11, 2019**

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – present	Kelly Garcia – present
Kimberly Kudej – present	Mikki Stier - present
Sam Wallace – present	Rick Schults - present
Carol Forristall – present	Julie Lovelady - present
Rebecca Peterson – present	Carrie Malone - present
Skylar Mayberry-Mayes - present	Matt Highland - present
	Julie Dougherty - present
	Nancy Freudenberg - present

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – absent
Representative Timi Brown-Powers - absent
Senator Amanda Ragan – present
Senator Mariannette Miller-Meeks – absent

Guests

Adrienne Erazo – DHS
 Erin Davison-Rippey – PPNCS
 Sheena Dooley – PPNCS
 Stacie Maas – ITC
 Jane Hudson - DRI

Flora Schmidt – IBHA
 Natalie Krebs - IPR
 Kris Bell – SDC
 Sandi Hurtado-Peters – IDOM

Call to Order

Chair Mark Anderson called the Council meeting to order at 10:00 a.m. in the first floor conference room at the Hoover State Office Building in Des Moines, IA.

Roll Call

Five council members were present.
 One Ex-officio legislative member was present, three were absent.

Approval of Minutes

A motion was made by Wallace and seconded by Forristall to approve the minutes of the November 13, 2019 meeting.

MOTION UNANIMOUSLY CARRIED

Rules

The following amendment to the administrative rules is presented for adoption at the December 11, 2019, meeting of the Council on Human Services: Due to the comment period just ending on November 26, 2019, rules there was not sufficient time to gather the comments and propose changes for your review for the other noticed rules that were under review. Those rules will be presented at the January meeting.

R-1. Amendments to Chapter 73, “Managed Care”. 2019 Iowa Acts, House file 766, Section 63, requires the Department to adopt rules to require that both managed care and fee for service payment and delivery systems utilize a uniform process, including but not limited to uniform forms, information requirements, and time frames, to request medical prior authorizations under the Medicaid program.

A motion was made by Wallace to approve and seconded by Forristall.

MOTION UNANIMOUSLY CARRIED.

The following amendments to the administrative rules are presented as Notice of Intended Action for review by the Council.

N-1. Amendments to Chapter 79, “Other Policies Relating to Providers of Medical and Remedial Care.” This rule implements HF 766, which updates the Medical Assistance Advisory Council (MAAC) and Executive Committee meeting rules regarding membership, voting, and duties. This amendment also removes the Executive committee and its responsibilities. .

N-2. Amendments to Chapter 79, “Other Policies Relating to Providers of Medical and Remedial Care,” and Chapter 83, “Medicaid Waiver Services”. This rule implements HF 760 which directs the department to eliminate the monthly budget maximum or cap for individuals eligible for the Medicaid home and community–based brain injury waiver. This rule also implements HF 766 which appropriates additional funds to adjust the per diem rates for assertive community treatment (ACT) services.

N-3. Amendments to Chapter 95, “Collections.” This rule eliminates references to the application fee paid by non-assistance customers when requesting services from the Child Support Recovering Unit (CSU). Recent legislative changes to Iowa Code Chapter 252B.4 under eliminated he customer paid fee. SF 605 also increased the annual fee for non-assistance child support cases.

A motion was made by Wallace and seconded by Forristall to approve the noticed rules. **MOTION UNANIMOUSLY CARRIED.**

Family Planning Update

Julie Lovelady, Deputy Director of Medicaid, gave an overview of the Family Planning Update.

Update on Park and Institutional Roads Program

MHDS DA Rick Shults provided the council with a review of roads program.

Director's Report

Director Garcia spoke to the council about the recent investigation by the Department of Justice at Glenwood and Woodward Resource Centers. She provided the council with a brief update regarding Glenwood and how DHS is fully cooperating with the investigation. Director Garcia mentioned that she met with a team of Doctors from the University of Iowa hospitals and clinics that were brought in to make ensure the patients there are ok and are being well taken care of. She informed the council she will keep them updated on any additional information related to the investigation.

The next meeting of the Council on Human Services will be a conference call on January 8, 2020 in the Cabinet room at the Hoover State Office Building.

Adjournment

Chair Mark Anderson adjourned the meeting at 10:58 a.m.

Respectfully Submitted by,
Julie Dougherty
Council Secretary
JD



STATE OF IOWA
invites applications for the position of:

Division Administrator - Facilities

SALARY: \$46.68 - \$72.90 Hourly
\$3,734.40 - \$5,832.00 Biweekly
\$97,094.40 - \$151,632.00 Annually

LOCATION: Des Moines - 50319 - Polk County

JOB TYPE: Full-time

AGENCY: 401 Dept of Human Services - Central Office

OPENING DATE: 12/31/19

CLOSING DATE: 01/31/20 04:30 PM

LINKEDIN TAG: #LI-POST

POINT OF CONTACT: Hiring Manager at HR@dhs.state.ia.us

TO APPLY: For consideration applicants must include a resume, and cover letter.

JOB DESCRIPTION:

This is a non-merit position with the Department of Human Services - Central Office.

In addition to applying on NEOGOV, Candidates must follow the instructions in the "To Apply" section.

Become a team member of The Iowa Department of Human Services (DHS). DHS is seeking qualified candidates for the position of Administrator of Mental Health and Disability Services (MHDS) Facilities. This position provides leadership, direction and executive oversight over the six MHDS facilities that include – two psychiatric hospitals, two residential treatment facilities for individuals with intellectual disabilities, a civil commitment unit for sexual offenders, and the boys' state training school.

Iowa is a Medicaid expansion state with a broad array of Medicaid covered behavioral health services and extensive home and community-based services waivers for individuals with a serious mental illness, children with a serious emotional disturbance and individuals with an intellectual disability. The Division works closely with the Department's Community Services and Targeted Case Management team; Medicaid Bureau; Adult, Children, and Family Services; Iowa Department of Public Health's Substance Use Disorder Treatment Bureau, and the Department of Education and the judiciary and law enforcement to design, develop, and implement public mental health and disability services in Iowa. In addition to Medicaid and MHDS Facilities' budgets, the Department's six facilities have operating budgets of about \$205 million with approximately 1850 full time equivalent employees. 5 superintendents, more than 80 medical staff that includes 6 physicians and serve approximately 2,000 Iowans with the most severe and complex needs. The Department has five separate campus sites covering 2,249 acres with 290 buildings.

Statewide travel is required, with recurring onsite visits to each facility located across the Iowa in Cherokee (Mental Health Institution and Civil Commitment Unit for Sex Offenders), Eldora (Boys State Training School), Glenwood (Resource Center), Independence (Mental Health Institution) and Woodward (Resource Center).

This is an at-will, merit exempt senior level management position with a direct reporting relationship to

the Department of Human Services Director.

LOCATION: The position is located in Des Moines, Iowa. Des Moines is ranked 5th best to live in the United States by US News and World Report. Des Moines offers a myriad of cultural events, vibrant restaurants, excellent bike trails and parks, exceptional schools, and an affordable housing and cost of living.

More information can be found at <https://www.governmentjobs.com/careers/iowa>

Our agency uses E-Verify to confirm the employment eligibility of all newly hired employees. To learn more about E-Verify, including your rights and responsibilities, please visit www.dhs.gov/E-Verify.

Posting for this position closes January 31, 2020.

MINIMUM QUALIFICATION REQUIREMENTS:

Applicants must meet at least one of the following minimum requirements to qualify for positions in this job classification:

- 1) Graduation from an accredited four-year college or university and experience equal to seven years of full-time management-level work in finance, human resources, engineering, law, social work, regulation, data processing, or program research or evaluation.
- 2) Eleven years of full-time management-level work experience in finance, human resources, engineering, law, social work, regulation, data processing, or program research or evaluation.
- 3) All of the following (a and b):
 - a. Seven years of full-time management-level work experience in finance, human resources, engineering, law, social work, regulation, data processing, or program research or evaluation; and
 - b. A combination of a total of four years of education and full-time experience (as described in part a), where thirty semester hours of accredited college or university course work in any field equals one year of full-time experience. Graduation from the Iowa Certified Public Manager Program is also equivalent to one year of full-time experience or education.
- 4) All of the following (a, b, and c):
 - a. Five years of full-time management-level work experience in finance, human resources, engineering, law, social work, regulation, data processing, or program research or evaluation; and
 - b. A combination of a total of four years of education and full-time experience (as described in part a), where thirty semester hours of accredited college or university course work in any field equals one year of full-time experience; and
 - c. A combination of a total of two years of graduate-level education and full-time experience (as described in part a), where twenty-four semester hours of accredited graduate college or university course work in a public-service-related area (e.g., public or business administration, social work, law, education, engineering) equals one year of full-time experience. Graduation from the Iowa Certified Public Manager Program is also equivalent to one year of full-time experience or education.
- 5) Current, continuous experience in the state executive branch that includes one year of full-time work as a Public Service Manager 1, Public Service Manager 2, or comparable specific management-level position.

For additional information, please click on this [link to view the job description](#).

TO CONTACT THE HIRING AGENCY:

Position #20-01650
DIVISION ADMINISTRATOR - FACILITIES
MW

<http://dhs.iowa.gov/>

To Contact DAS HRE: dashre.info@iowa.gov

Please Note: The Hiring Agency listed above is responsible for all decisions regarding interviews and hiring. Please contact them if you have questions.

The State of Iowa is an Equal Opportunity/Affirmative Action Employer.



STATE OF IOWA
invites applications for the position of:

Division Administrator

SALARY: \$46.68 - \$72.90 Hourly
\$3,734.40 - \$5,832.00 Biweekly
\$97,094.40 - \$151,632.00 Annually

LOCATION: Des Moines - 50319 - Polk County

JOB TYPE: Full-time

AGENCY: 401 Dept of Human Services - Central Office

OPENING DATE: 01/02/20

CLOSING DATE: 01/31/20 11:59 PM

LINKEDIN TAG: #LI-POST

POINT OF CONTACT: HR@dhs.state.ia.us

TO APPLY: For consideration please apply through NEOGOV and submit your resume and cover letter to HR@dhs.state.ia.us.

JOB DESCRIPTION:

This is a non-merit position with the Iowa Department of Human Services.

In addition to applying on NEOGOV, Candidates must follow the instructions in the "To Apply" section.

Only applicants who meet the Minimum Qualification Requirements and meet all selective requirements will be placed on the eligible list.

Salary range \$97,094 to \$151,632
Commensurate with skills and experience
Employee-employer-paid retirement plan and health insurance

Become a member of The Iowa Department of Human Services (DHS) team. DHS is seeking qualified candidates for the position of Administrator of Mental Health and Disability Services (MHDS) – Community Services and Targeted Case Management. This position provides leadership, direction and executive oversight over MHDS Community Services and Planning and State Provided Case Management to serve and support Iowans to live safe, healthy, self-determined lives in their homes and communities.

Iowa is a Medicaid expansion state with a broad array of Medicaid covered behavioral health services and extensive home and community-based services waivers for individuals with a serious mental illness, children with a serious emotional disturbance and individuals with an intellectual disability. The mental health and disability system includes 14 county-based MHDS Regions, community mental health centers, private in-patient psychiatric hospitals, and psychiatric residential treatment facilities. Iowa's MHDS Regions spend \$112 M. for mental health and disability services for individuals not eligible for Medicaid or covered by other insurance. The Division works closely with the Department's six Facilities, Medicaid Bureau; Adult, Children, and Family Services; Iowa Department of Public Health's Substance Use Disorder Treatment Bureau, and the Department of Education and the judiciary and law enforcement to design, develop, and implement public mental health and disability services in Iowa. In

addition to Medicaid and MHDS Regions' budgets, the MHDS Community Services and Targeted Case Management division has an annual operating budget of approximately \$14 million and employs about 65 staff.

Statewide travel is required.

This is an at-will, merit exempt senior level management position with a direct reporting relationship to the Department of Human Services Director.

EDUCATION: A Bachelor's degree with major course work in psychology, social work public health, health administration, business administration, public administration, or related field is preferred.

EXPERIENCE: A minimum of five years executive or administrative experience which includes administering the operations of a comprehensive behavioral health ,intellectual disabilities, public health organization or major division along with demonstrated knowledge or experience in: the law, theories and principles related to behavioral and/or public health; best practices in the field of behavioral and/or public health; program planning, development and evaluation; public administration to include strategic planning, policy development and the administration and oversight of a complex budget; human resources management with ability to effectively lead an organization through change; the health care field to include ability to implement federal health care standards and requirements associated with health care reform; the legislative process to include working cooperatively with legislators and presenting legislation, services and budgets before legislative committees; demonstrated public speaking skills and facilitation of high profile meetings and initiatives; collaborating and engaging governmental , private entities, law enforcement, judges, defense attorneys and prosecutors and stakeholders (including families and service recipients); **OR** an equivalent combination of education and experience.

LOCATION: The position is located in Des Moines, Iowa. Des Moines is ranked 5th best to live in the United States by US News and World Report. Des Moines offers a myriad of cultural events, vibrant restaurants, excellent bike trails and parks, exceptional schools, and an affordable housing and cost of living.

More information can be found at <https://www.governmentjobs.com/careers/iowa>

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For consideration please submit your resume and cover letter to HR@dhs.state.ia.us.

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SELECTIVES:

058 Budgeting

6 months' experience, 12 semester hours, or a combination of both in preparing, analyzing budgets; and providing advice/technical assistance with cost analysis, fiscal allocation, and budget preparation.

AND

720 Policy Development

6 months' experience, 12 semester hours, or a combination of both in the development of written documents that will create policies, standards, and procedures.

AND

397 Mental Health

6 months' experience in providing service, treatment or assessment to those affected by mental health challenges, either in a private setting, group homes, local assistance agencies, or state or privately-run treatment institutions. Application must demonstrate that applicant has received a general orientation to the symptoms and treatment protocols for mental illness or public policies, procedures, or applicable laws related to the topic, or assistance programs for those affected by mental illness. Experience may come from public, private or non-profit organizations.

AND**545 Intellectual Disability**

A minimum of one year of full-time (or equivalent part-time) experience in delivering or coordinating services for persons with significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior manifested during the developmental period. This would include, but would not be limited to:

- House parents and counselors who work at group homes
- Sheltered work or work activities staff
- Treatment staff affiliated with the state resource centers at Glenwood and Woodward

MINIMUM QUALIFICATION REQUIREMENTS:

Applicants must meet at least one of the following minimum requirements to qualify for positions in this job classification:

- 1) Graduation from an accredited four-year college or university and experience equal to seven years of full-time management-level work in finance, human resources, engineering, law, social work, regulation, data processing, or program research or evaluation.
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- 3) All of the following (a and b):
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Position #20-01649
DIVISION ADMINISTRATOR
MW

<http://dhs.iowa.gov/>

To Contact DAS HRE: dashre.info@iowa.gov

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December 31, 2019

Dear Council Member:

The following amendments to the administrative rules are presented for adoption at the January 8, 2020, meeting of the Council on Human Services:

R-1. Amendments to Chapter 75, "Conditions of Eligibility." This rule will continue to allow an annual change in the statewide monthly standard deduction for personal care services provided in a licensed Residential Care Facility (RCF) based on the Consumer Price Index (CPI) for urban consumers. This annual change continues to be a benefit to Medically Needy members who reside in a licensed RCF because it allows the personal care needs to be applied to the spenddown obligation.

R-2. Amendments to Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and to Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care." This rulemaking updates and clarifies language to reflect existing prescribed outpatient drug policies for qualified prescribers, reasons for nonpayment of drugs, covered nonprescription drugs, quantity prescribed, drug reimbursement methodology and credits for returned unit dose drugs not consumed.

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Enterprise (IME) mailing address and made changes to reflect current operations of the IME.

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There are no Noticed rules this month.

Sincerely,

Nancy Freudenberg

Nancy Freudenberg
Bureau Chief
Policy Coordination

Enclosures

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

The Human Services Department hereby amends Chapter 75, "Conditions Of Eligibility," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 249.12.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249.12.

Purpose and Summary

This rule making will continue to allow an annual change in the statewide monthly standard deduction for personal care services provided in a licensed residential care facility (RCF) based on the Consumer Price Index (CPI) for All Urban Consumers. This annual change continues to benefit medically needy members who reside in licensed RCFs because it continues to allow personal care needs to be applied to the spenddown obligation.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on November 6, 2019, as **ARC 4738C**.

No public comments were received.

No changes from the Notice have been made.

Adoption of Rule Making

This rule making was adopted by the Council on January 8, 2020.

Fiscal Impact

There is minimal fiscal impact expected as a result of this rule.

Jobs Impact

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

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date This rule making will become effective on March 18, 2020.

The following rule-making action is adopted:

Amend subparagraph 75.1(35)“g”(2) as follows:

(2) Order of deduction. Spenddown shall be adjusted when a bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a bill for a covered service incurred prior to the certification period is subsequently received. Spenddown shall also be adjusted when a bill for a noncovered Medicaid service is subsequently received with a service date prior to the Medicaid-covered service. Spenddown shall be adjusted when an unpaid bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a paid bill for a covered service incurred in the certification period is subsequently received with a service date prior to the date of the notice of spenddown status.

If spenddown has been met and a bill is received with a service date after spenddown has been met, the bill shall not be deducted to meet spenddown.

Incurred medical expenses, including those reimbursed by a state or political subdivision program other than Medicaid, but excluding those otherwise subject to payment by a third party, shall be deducted in the following order:

1. Medicare and other health insurance premiums, deductibles, or coinsurance charges.

EXCEPTION: When some of the household members are eligible for full Medicaid benefits under the Health Insurance Premium Payment Program (HIPP), as provided in rule 441—75.21(249A), the health insurance premium shall not be allowed as a deduction to meet the spenddown obligation of those persons in the household in the medically needy coverage group.

2. An average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed residential care facility shall be allowed as a deduction for spenddown. These personal care services include assistance with activities of daily living such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication.

The average statewide monthly standard deduction for personal care services shall be based on the average per day rate of health care costs associated with residential care facilities participating in the state supplementary assistance program for a 30.4-day month as computed ~~in the Compilation of Various Costs and Statistical Data (Category: All; Type of Care: Residential Care Facility; Location: All; Type of Control: All)~~ by multiplying the previous year's average per day rate by the inflation factor increase during the preceding calendar year ending December 31 of the Consumer Price Index for All Urban Consumers as published by the Bureau of Labor Statistics. ~~The average statewide standard deduction for personal care services used in the medically needy program shall be updated and effective the first day of the first month beginning two full months after the release of the Compilation of Various Costs and Statistical Data for the previous fiscal year.~~

3. Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.

4. Medical expenses for acupuncture, chronologically by date of submission.

5. Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.



Iowa Department of Human Services
Information on Proposed Rules

Name of Program Specialist Karen Jones	Telephone Number 515-281-8635	Email Address kjones2@dhs.state.ia.us
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1. Give a brief purpose and summary of the rulemaking:

The average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed Residential Care Facility (RCF) are allowed as a deduction for the Medically Needy coverage group spenddown. This deduction was based on the average per day rate of health care costs associated with RCFs participating in the state supplementary assistance program for a 30.4 day month as computed from submitted cost reports. This deduction is applied to the members Medically Needy spenddown. When the spenddown is met, the member becomes Medicaid eligible for the certification period.

Due to the amendment of Iowa Code 249.12, which eliminates the requirement for privately operated licensed Residential Care Facilities (RCFs) to complete and submit annual cost reports, the Department is changing how they determine the average statewide monthly standard deduction for personal care services.

The Department decided we will multiply the previous year's average per day rate by the inflation factor increase during the preceding calendar year ending December 31 of the Consumer Price Index (CPI) for Urban Consumers as published by the Bureau of Labor Statistics to calculate the current year's deduction for personal care services.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

Iowa Code 249.12

3. Describe who this rulemaking will positively or adversely impact.

This rulemaking will continue to allow an annual change in the average statewide monthly standard deduction for personal care services provided in a licensed RCF based on the CPI for Urban Consumers. This annual change continues to be a benefit to the Medically Needy member who resides in a licensed RCF because it continues to allow the personal care services to be applied toward spenddown obligations.

4. Does this rule contain a waiver provision? If not, why?

No. This amendment does not contain waiver provisions because it confers a benefit. Individuals may request an exception pursuant to the Department's general rule on exceptions to policy at 441 IAC 1.8.

5. What are the likely areas of public comment?

Public comment on the change on how we calculate the average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed RCF is unlikely since the amendment to the rule will continue to result in an annual change.

6. 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.)

No.



Administrative Rule Fiscal Impact Statement

Date: April 22, 2019

Agency: Human Services
IAC citation: 441 IAC 75.1(35)"g"(2)2
Agency contact: Karen Jones

Summary of the rule:

Due to the amendment of Iowa Code 249.12, which eliminates the requirement for privately operated licensed Residential Care Facilities (RCFs) to complete and submit annual cost reports, the Department is changing how they determine the average statewide monthly standard deduction for personal care services by multiply the previous year's average per day rate by the inflation factor increase during the preceding calendar year ending December 31 of the Consumer Price Index (CPI) for Urban Consumers as published by the Bureau of Labor Statistics.

Fill in this box if the impact meets these criteria:

- No fiscal impact to the state.
 Fiscal impact of less than \$100,000 annually or \$500,000 over 5 years.
 Fiscal impact cannot be determined.

Brief explanation:

Budget Analysts must complete this section for ALL fiscal impact statements.

It is not anticipated that this change in calculating the deduction will provide much of a different result compared to the old way of calculating the deduction. As previous, the rate could go up or down. Here is an example of the amount of the change for 2019 using the new calculation:

2018 allowable deduction: \$25.96 per day, \$789.18 per month
CPI-U for 12 months ending December 2018: 1.9%

$\$25.96(0.019)=0.49324$ (rounded up to \$0.50)
 $\$25.96+\$0.50=\$26.46$
 $\$26.46(\times 30.4)=\804.384 (rounded up to \$804.39)

The above increase equates to \$.50 per day increase for 2019, or a difference of \$15.21 per month.

The prior year's rate was \$24.49 per day and \$744.50 per month. Compared to the current rate of \$25.96, this resulted in a difference of \$1.47 per day and \$44.68 per month.

The rate in the prior year to that was \$23.40 per day and \$711.36 per month. Compared to the previous rate of \$24.49, this resulted in a difference of \$1.09 per day and \$33.00 per month.

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.

Funding has not been provided for the rule.

Please explain how the agency will pay for the rule change:

Not applicable as the rule change will continue to result in an annual change with minimal impact.

Fiscal impact to persons affected by the rule:

Minimal impact. This rulemaking will continue to allow an annual change in the average statewide monthly standard deduction for personal care services provided in a licensed RCF based on the CPI for Urban Consumers. This annual change continues to be a benefit to the Medically Needy member who resides in a licensed RCF because it continues to allow the personal care services to be applied toward spenddown obligations.

Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):

No impact.

Agency representative preparing estimate: Jason Buls

Telephone number: 515-281-5764

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rule making related to medical and remedial services

Legal Authority for Rule Making

This rule making is proposed under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4.

Purpose and Summary

This rule making updates and clarifies language to reflect existing prescribed outpatient drug policies for qualified prescribers, reasons for nonpayments of drugs, covered nonprescription drugs, quantity prescribed, drug reimbursement methodology (including dispensing fee limitation) and credits for returned unit dose drugs not consumed. This rule making also adds language regarding initiation of refill requirements with the prohibition of automatic refills without the member's consent and includes legislatively required prior authorization (PA) limitations on medication-assisted treatment (MAT), including opioid overdose treatment, under the pharmacy and medical benefits.

Public Comment and Changes to Rule Making

The Department received seven comments from two respondents regarding the proposed changes: Flora A. Schmidt, Executive Director, Iowa Behavioral Health Association; and Casey Ficek, J.D., Director, Public Affairs, Iowa Pharmacy Association.

The comments and corresponding responses from the Department are divided into five topic areas as follows:

1. **Non-payment of drugs.** Two comments were received on this topic.
 - One respondent commented the rules, in not allowing payment for drug products administered in a practitioner's office, outpatient clinic or infusion center, may limit access to Medication Assisted Treatment (MAT) drugs at Opioid Treatment Programs, MAT Unit sites and Mental Health Centers and Substance Abuse treatment facilities. The respondent requested deletion or amend with exceptions for behavioral health facilities.

- One respondent commented, in not allowing payment for drug products administered in a practitioner's office, outpatient clinic or infusion center, while current policy under Medicaid, has resulted in some access issues for certain therapies provided in an infusion center controlled setting for Medicaid patients and request reconsideration.

Department Response: The Department will further research the access concerns identified in the comments before formalizing the policy in rules, so this statement has been removed.

2. Prior authorization for medication-assisted treatment drugs. Two comments were received on this topic.

- One respondent recommended a formatting change for the rule language and requested deletion of added language, as she indicated it was not in the legislative language for this requirement.

Department Response: The Department inserted a line break return after the last drug in the list. The language "opioid overdose agent" clarifies that naltrexone is approved by the Food and Drug Administration (FDA) for the treatment of opioid overdose. The Department revised the language to clarify.

- One respondent supported the removal of the prior authorization requirements to increase access to treatment for opioid use disorder.

Department Response: The Department agrees with the comment. Increased access to treatment was the reason the Department initiated removal of the prior authorization requirement in the administrative rules.

3. Qualified prescriber. One comment was received on this topic.

- One respondent supports the change to eliminate the list of specific qualified prescribers to ensure this will not have to be continually updated to reflect future changes in state law.

Department Response: The Department agrees with the comment, and this was the reason the department initiated removal of the prescriber list in the administrative rules.

4. Professional dispensing fee. One comment was received on this topic.

- One respondent is concerned about how one dispensing per month may affect patients seeking to utilize medication synchronization services, patients residing in nursing home and long-term care facilities, and prepacked drugs in less than a 30-day supply (ex. oral contraceptives).

Department Response: Medication synchronization services are not a currently covered policy under Medicaid and this rule language will not change that. If a pharmacy makes a business model decision to service nursing homes and long-term care facilities, that pharmacy has the ability to continue billing according to its existing process (ex. less than a month's supply). However, a dispensing fee will only be reimbursed once a month for maintenance drugs. Additionally, the pharmacy may choose to accumulate the billing to once a month as is the current process these pharmacies utilize for controlled substances. Lastly, the dispensing fee programming takes into account the monthly package size in allowing payment of a dispensing fee in accordance with the refill tolerance of 90% consumption. A dispensing fee would be allowed on a 28-day oral contraceptive when the refill is allowed on the 25th day. The Department updated the dispensing fee language to account for the refill tolerance.

5. **Unit dose packaging credits.** One comment was received on this topic.

- Respondent commented returns of unit dose packaging by a pharmacy must be consistent with Iowa Board of Pharmacy rules and the Department's rule language would result in pharmacies losing the cost of the medication returned and credited.

Department Response: The Department agrees a pharmacy must follow the Iowa Board of Pharmacy rules on drug returns and has added that wording to the rules to clarify. This language is consistent with guidance in Informational Letter No. 497 released on April 21, 2006, and in the Prescribed Drugs Provider Manual.

Adoption of Rule Making

This rule making was adopted by the Council on Human Services on January 8, 2020

Fiscal Impact

Removal of clinical PA for MAT drugs is projected to have the following impacts:

- For the pharmacy benefit: It is estimated removing the PA requirement would result in additional expenditures for this category of drugs. There would be increased prescribing/utilization.

- Pharmacy benefit increased expenditures are estimated at the following: Total dollars before rebates \$80,000 (\$24,000 state share); \$35,000 net of rebates (\$10,500 state share). The state share is based on a blend between the traditional Medicaid and Iowa Health and Wellness Plan populations. This fiscal impact is a combined total for both fee-for-service (FFS) and managed care programs.

- There are no associated programming costs with this change.
- For the medical benefit: There is no fiscal impact as none of these drugs require a PA under the medical benefit.
- Medical contracts: No impact projected to the Medical Contracts General Fund Appropriation.

Enforcement of the dispensing fee allowance on maintenance drugs is projected to have the following impacts:

- Clarifying the quantity prescribed and dispensing fee allowance could result in savings to the Medicaid program in cases where a pharmacy has been reimbursed greater than one dispensing fee per drug per member per month for maintenance drugs.

- The annualized savings is projected to be as follows per program based on the current dispensing fee of \$10.07 and current utilization:

- FFS \$31,418 total (state and federal) dollars (based on April 2019 data and annualized).
- Amerigroup \$336,000 (based on April 2019 data and annualized).
- UnitedHealthcare \$660,965 (based on March 2019 data and annualized).

For both changes, PA removal and limit of one dispensing fee, the managed care organization (MCO) cost impact is part of the capitation rate setting.

Jobs Impact

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

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on March 18, 2020.

The following rule-making actions are adopted:

ITEM 1. Amend subrule 78.1(18) as follows:

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross reference ~~78.28(3)~~ 78.28(4))

ITEM 2. Adopt the following **new** subrule 78.1(25):

78.1(25) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

ITEM 3. Amend subrules 78.2(1) to 78.2(6) as follows:

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed by a legally qualified practitioner (~~physician, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner~~). Pursuant to Public Law 111-148, Section 6401, any practitioner prescribing drugs must be enrolled with the Iowa Medicaid enterprise in order for such prescribed drugs to be eligible for payment.

78.2(2) and 78.2(3) No change.

78.2(4) *Prescription drugs.* Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A ~~as amended by 2010 Iowa Acts, Senate File 2088, section 347.~~

(1) to (3) No change.

(4) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

b. Payment is not made for:

(1) to (7) No change.

(8) Drugs prescribed for fertility purposes, ~~except when prescribed for a medically accepted indication other than infertility, as defined in subparagraph (1).~~

(9) to (12) No change.

78.2(5) Nonprescription drugs.

a. The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg

Acetaminophen elixir 160 mg/5 ml

Acetaminophen solution 100 mg/ml

Acetaminophen suppositories 120 mg

Artificial tears ophthalmic solution

Artificial tears ophthalmic ointment

Aspirin tablets 81 mg, chewable

Aspirin tablets 81 mg, 325 mg, and 650 mg, ~~81 mg (chewable)~~ oral

Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg

Aspirin tablets, buffered 325 mg

Bacitracin ointment 500 units/gm

Benzoyl peroxide 5%, gel, lotion

Benzoyl peroxide 10%, gel, lotion

~~Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg~~

Calcium carbonate suspension 1250 mg/5 ml

Calcium carbonate tablets 600 mg

~~Calcium carbonate-vitamin D tablets 500 mg-200 units~~

~~Calcium carbonate-vitamin D tablets 600 mg-200 units~~

~~Calcium citrate tablets 950 mg (200 mg elemental calcium)~~

~~Calcium gluconate tablets 650 mg~~

~~Calcium lactate tablets 650 mg~~

Cetirizine hydrochloride liquid 1 mg/ml

Cetirizine hydrochloride tablets 5 mg

Cetirizine hydrochloride tablets 10 mg

Chlorpheniramine maleate tablets 4 mg

Clotrimazole vaginal cream 1%

Diphenhydramine hydrochloride capsules 25 mg

Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml

Epinephrine racemic solution 2.25%

Ferrous sulfate solution 75 mg/0.6 ml (15 mg/0.6 ml elemental iron)

Ferrous sulfate tablets 325 mg

Ferrous sulfate elixir 220 mg/5 ml

Ferrous sulfate drops 75 mg/0.6 ml

Ferrous gluconate tablets 325 mg

Ferrous fumarate tablets 325 mg

Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid

Ibuprofen suspension 100 mg/5 ml

Ibuprofen tablets 200 mg

Insulin

Lactic acid (ammonium lactate) lotion 12%

Levonorgestrel 1.5 mg

Loperamide hydrochloride liquid 1 mg/5 ml

Loperamide hydrochloride liquid 1 mg/7.5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml
Loratadine tablets 10 mg
Magnesium hydroxide suspension 400 mg/5 ml
~~Magnesium oxide capsule 140 mg (85 mg elemental magnesium)~~
~~Magnesium oxide tablets 400 mg~~
Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
Miconazole nitrate cream 2% topical and vaginal
Miconazole nitrate vaginal suppositories, 100 mg
~~Multiple vitamin and mineral products with prior authorization~~
Neomycin-bacitracin-polymyxin ointment
~~Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg~~
Nicotine gum 2 mg, 4 mg
Nicotine lozenge 2 mg, 4 mg
Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
Pediatric oral electrolyte solutions
Permethrin lotion 1%
Polyethylene glycol 3350 powder
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
Pseudoephedrine hydrochloride liquid 30 mg/5 ml
Pyrethrins-piperonyl butoxide liquid 0.33-4%
Pyrethrins-piperonyl butoxide shampoo 0.3-3%
Pyrethrins-piperonyl butoxide shampoo 0.33-4%
Salicylic acid liquid 17%
Senna tablets 187 mg
Sennosides-docusate sodium tablets 8.6 mg-50 mg
Sennosides syrup 8.8 mg/5 ml
Sennosides tablets 8.6 mg
Sodium bicarbonate tablets 325 mg
Sodium bicarbonate tablets 650 mg
Sodium chloride hypertonic ophthalmic ointment 5%
Sodium chloride hypertonic ophthalmic solution 5%
Tolnaftate 1% cream, solution, powder
Vitamins, single and multiple with prior authorization

Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

b. No change.

78.2(6) *Quantity prescribed and dispensed.*

a. Quantity prescribed. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity not less than a one-month supply of covered prescription and nonprescription medication sufficient for up to a 31-day supply. Oral contraceptives Contraceptives may be prescribed in 90-day three-month quantities.

b. ~~Oral solid forms of covered nonprescription items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription or the currently available consumer package size except when dispensed via a unit-dose system.~~

b. Prescription refills.

(1) Prescription refills shall be performed and recorded in a manner consistent with existent state and federal laws, rules and regulations.

(2) Automatic refills.

1. Automatic refills are not allowed. A request specific to each medication is required.

2. All prescription refills shall be initiated by a request at the time of each fill by the prescriber, Medicaid member or person acting as an agent of the member, based on continued medical necessity.

ITEM 4. Amend rule 441—78.3(249A), introductory paragraph, as follows:

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross reference ~~78.28(5)~~ 78.28(6)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

ITEM 5. Amend subrule 78.3(18) as follows:

78.3(18) Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from the IME medical services unit. (Cross reference ~~78.28(5)~~ 78.28(6))

ITEM 6. Amend subrule 78.4(4) as follows:

78.4(4) Periodontal services. Payment may be made for the following periodontal services:

a. No change.

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference ~~78.28(2)“a”(1)~~ 78.28(3)“a”(1))

c. No change.

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross reference ~~78.28(2)“a”(2)~~ 78.28(3)“a”(2))

e. Periodontal maintenance therapy requires prior authorization. Approval shall be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference ~~78.28(2)“a”(3)~~ 78.28(3)“a”(3))

f. and g. No change.

ITEM 7. Amend subparagraph **78.4(5)“c”(2)** as follows:

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross reference ~~78.28(2)“e”~~ 78.28(3)“c”)

ITEM 8. Amend subrule 78.4(7) as follows:

78.4(7) Prosthetic services. Payment may be made for the following prosthetic services:

a. and b. No change.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross reference ~~78.28(2)“b”(1)~~ 78.28(3)“b”(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who:

(1) and (2) No change.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross reference ~~78.28(2)“b”(2)~~ 78.28(3)“b”(2))

e. to n. No change.

ITEM 9. Amend paragraph **78.4(8)“a”** as follows:

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross reference ~~78.28(2)“e”~~ 78.28(3)“c”)

ITEM 10. Amend subrule 78.6(4) as follows:

78.6(4) Prior authorization. Prior authorization is required for the following:

a. to d. No change.

e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(Cross reference ~~78.28(3)~~ 78.28(4))

ITEM 11. Amend rule 441—78.7(249A), introductory paragraph, as follows:

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross reference ~~78.28(3)~~ 78.28(4))

ITEM 12. Amend subrule 78.9(10) as follows:

78.9(10) Private duty nursing or personal care services for persons aged 20 and under. Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. No change.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) 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. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference ~~78.28(9)~~ 78.28(10))

ITEM 13. Amend subparagraph **78.10(3)"b"(10)** as follows:

(10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross reference ~~78.28(4)~~ 78.28(5))

ITEM 14. Amend subparagraphs **78.14(7)"d"(1)** and **(2)** as follows:

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross reference ~~78.28(4)"a"~~ 78.28(5)"a")

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference ~~78.28(4)"b"~~ 78.28(5)"b"):

1. and 2. No change.

ITEM 15. Amend paragraph **78.26(4)"c"** as follows:

c. Preprocedure review by the IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from the IME medical services unit. (Cross reference ~~78.28(6)~~ 78.28(7))

ITEM 16. Renumber subrules **78.28(2)** to **78.28(11)** as **78.28(3)** to **78.28(12)**.

ITEM 17. Adopt the following **new** subrule 78.28(2):

78.28(2) Notwithstanding the provisions of 78.28(1)"a," under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs for medication-assisted treatment as approved by the United States food and drug administration for treatment of substance use disorder or overdose treatment will be available without prior authorization:

- a. Buprenorphine,
- b. Buprenorphine and naloxone combination,
- c. Methadone,
- d. Naltrexone, and
- e. Naloxone.

For the purpose of this subrule, “medication-assisted treatment” means the medically monitored use of certain substance use disorder medications in combination with treatment services.

ITEM 18. Amend renumbered paragraphs 78.28(12)“a” and “b” as follows:

a. Except as provided in paragraph ~~78.28(11)“b,”~~ 78.28(12)“b,” the following radiology procedures require prior approval:

(1) to (5) No change.

b. Notwithstanding paragraph ~~78.28(11)“a,”~~ 78.28(12)“a,” prior authorization is not required when any of the following applies:

(1) and (2) No change.

(3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member’s receipt of such notice (see paragraph ~~78.28(11)“e”~~ 78.28(12)“e”); or

(4) No change.

ITEM 19. Amend paragraphs 79.1(8)“a” to “g” as follows:

a. Except as provided below in paragraphs 79.1(8)“d” through “i,” all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph ~~79.1(8)“e.”~~ 79.1(8)“c”;

2. The federal upper limit (FUL), defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514(a)-(c), plus the professional dispensing fee determined pursuant to paragraph ~~79.1(8)“e.”~~ 79.1(8)“c”;

3. The total submitted charge, represented by the lower of the gross amount due (GAD) as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee, determined pursuant to paragraph 79.1(8)“e”; or

4. Providers’ usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph ~~79.1(8)“e.”~~ 79.1(8)“c”;

2. The total submitted charge, represented by the lower of the GAD as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee; or

3. Providers’ usual and customary charge to the general public.

b. No change.

c. Professional dispensing fee.

(1) For purposes of this subrule, the professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries. The survey shall be conducted every two years beginning in state fiscal year 2014-2015.

(2) There is a one-time professional dispensing fee reimbursed per one-month or three-month period, accounting for the refill tolerance of 90% consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose shall be added to reimbursement based on acquisition cost or FUL. Payment may be made only for unit-dose-packaged drugs that are consumed by the patient. Any previous charges for unused unit-dose packages returned to the pharmacy must be credited to the Medicaid program, consistent with the Iowa Board of Pharmacy rules on return of drugs.

e. 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8) "a" above, reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The submitted 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

2. The average state AAC determined pursuant to paragraph 79.1(8) "b" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8) "a"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

4. The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

5. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4), will be according to paragraph 79.1(8) "a" because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8) "a" above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider's actual acquisition cost, (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(2) The average state AAC determined pursuant to paragraph 79.1(8) "b" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8) "a"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8) "a" above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's

“best price” pursuant to 42 CFR 447.508 will be the lowest of:

(1) The provider’s actual acquisition cost (not to exceed the nominal price paid), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8) “c”;

(2) The average state AAC determined pursuant to paragraph 79.1(8) “b” plus the professional dispensing fee pursuant to paragraph 79.1(8) “c”;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8) “a”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8) “c”;

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers’ usual and customary charge to the general public.

Comments and Responses on ARC 4763C
Prescribed Outpatient Drugs
Received December 10, 2019

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

1. Flora A. Schmidt, Executive Director, Iowa Behavioral Health Association
2. Casey Ficek, J.D., Director, Public Affairs, Iowa Pharmacy Association

The Department received 7 comments from two respondents on the proposed rules. The comments and corresponding responses from the Department are divided into 5 topic areas as follows:

A. Non-payments of Drugs. *There were two comments in this topic area.*

1. One respondent commented the rules, in not allowing payment for drug products administered in a practitioner's office, outpatient clinic or infusion center, may limit access to Medication Assisted Treatment (MAT) drugs at Opioid Treatment Programs, MAT Unit sites and Mental Health Centers and Substance Abuse treatment facilities. The respondent requested deletion or amend with exceptions for behavioral health facilities.

2. One respondent commented, in not allowing payment for drug products administered in a practitioner's office, outpatient clinic or infusion center, while current policy under Medicaid, has resulted in some access issues for certain therapies provided in an infusion center controlled setting for Medicaid patients and request reconsideration.

Department Response: The department will further research the access concerns identified in the comments before formalizing the policy in rules, so this statement has been removed.

B. Prior Authorization for Medication Assisted Treatment Drugs. *There were two comments in this topic area.*

1. One respondent recommended a formatting change for the rule language and requested deletion of added language as indicated it was not in the legislative language for this requirement.

Department Response: The department inserted a line break return after the last drug in the list. The language "opioid overdose agent" clarifies that naltrexone is approved by the Food and Drug Administration (FDA) for the treatment of opioid overdose. The department revised the language to clarify.

2. One respondent supported the removal of the prior authorization requirements to increase access to treatment for opioid use disorder.

Department Response: The department agrees with the comment and was the reason the department initiated removal of the prior authorization requirement in the administrative rules.

C. Qualified Prescriber. *There was one comment in this topic area.*

1. One respondent supports the change to eliminate the list of specific qualified prescribers to ensure this will not have to be continually updated to reflect future changes in state law.

Department Response: The department agrees with the comment and was the reason the department initiated removal of the prescriber list in the administrative rules.

D. Professional Dispensing Fee. *There was one comment in this topic area.*

1. Respondent is concerned about how one dispensing per month may affect patients seeking to utilize medication synchronization services, patients residing in nursing home and long-term care facilities, and prepacked drugs in less than a 30-day supply (ex. oral contraceptives).

Department Response: Medication synchronization services are not a currently covered policy under Medicaid and this rule language will not change that. If a pharmacy makes a business model decision to service nursing homes and long-term care facilities, that pharmacy has the ability to continue billing according to their existing process (ex. less than a month's supply) however, a dispensing fee will only be reimbursed once a month for maintenance drugs. Additionally the pharmacy may choose to accumulate the billing to once a month as is the current process these pharmacies utilize for controlled substances. Lastly, the dispensing fee programming takes into account the monthly package size in allowing payment of a dispensing fee in accordance with the refill tolerance of 90% consumption. A dispensing fee would be allowed on a 28-day oral contraceptive when the refill is allowed on the 25th day. The department updated the dispensing fee language to account for the refill tolerance.

E. Unit Dose Packaging Credits. *There was one comment in this topic area.*

1. Respondent commented returns of unit dose packaging by a pharmacy must be consistent with Iowa Board of Pharmacy rules and the department's rule language would result in pharmacies losing the cost of the medication returned and credited.

Department Response: The department agrees a pharmacy must follow the Iowa Board of Pharmacy rules on drug returns and has added that wording to the rules to clarify. This language is consistent with guidance in Informational Letter No. 497 released on April 21, 2006, and in the Prescribed Drugs Provider Manual.



Iowa Department of Human Services
Information on Proposed Rules

Name of Program Specialist Susan Parker	Telephone Number 256-4634	Email Address sparker2@dhs.state.ia.us
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1. Give a brief purpose and summary of the rulemaking:

The rule clarifies coverage and reimbursement of drugs by updating and adding new language as follows:

- Removes parenthetical examples of qualified prescribers under 441 IAC 78.2(1) as list is not exhaustive and removal of examples eliminates the need to update in the future as others are authorized to prescribe.
- Addition of new prior authorization (PA) limitations (one form of each drug must be available without a PA) on medication-assisted treatment (MAT), including opioid overdose treatment, under the pharmacy and medical benefits as legislatively required.
- Clarifies conditions under which payment is not made for drugs under 441 IAC 78.2(4)(b). Change includes removal of outdated language under drugs prescribed for fertility purposes to be consistent with the approved state plan and clarifies the site of service limitation that exists in current policy.
- Updates the list of covered nonprescription drugs in 441 IAC 78.2(5) by adding products established as preferred on the preferred drug list, removal of products no longer available and reorganization of covered products for clarity.
- Clarifies the prescription and nonprescription drug quantity to be prescribed under 441 IAC 78.2(6) to reflect the intent to prescribe not less than a one-month supply unless therapeutically contraindicated. Also clarifies all contraceptives, not just oral, may be prescribed and billed in three-month quantities.
- Addition of pharmacy requirements for refill initiation prohibiting automatic refills and adding the requirement that each fill or refill be based on initiated requests from the prescriber, member, or other person acting as an agent of the member.
- Clarifies drug reimbursement methodology, definitions, submission requirements and dispensing fee allowance. The clarifications will result in billing and reimbursement consistency among all pharmacies as intended under the current policy.
- Includes existing requirement for credit of returned unit dose drugs as required under federal law and as relayed to providers in policy.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

2019 Iowa House File 623; Iowa Code 249A.4; 42 U.S.C. 1396r-8 and section 1903(i)(10) of the Social Security Act as amended by section 6033 of the Deficit Reduction Act of 2005.

3. Describe who this rulemaking will positively or adversely impact.

Pharmacies may be impacted if they currently do not bill a one-month supply of maintenance drugs at a time for members but rather bill several times a month. The proposed rule changes will result in the pharmacy being reimbursed only one dispensing fee per drug per strength per member per month per provider for maintenance drugs rather than multiple. Additionally pharmacies that utilize automatic refill processes or other refill processes not initiated by a prescriber, member, or other person acting as an agent of the member will be required to develop appropriate policies regarding refill initiation.

Prescribers of preferred drugs for medication-assisted treatment (MAT) including opioid overdose treatment will not be required to submit a clinical prior authorization (PA).

4. Does this rule contain a waiver provision? If not, why?

This amendment does not provide for waiver in specified situations because the policies addressed should apply in all cases and because a waiver can be requested under the Department's general rule on exceptions at Iowa Admin. Code r. 441--1.8.

5. What are the likely areas of public comment?

Pharmacies may oppose the requirement to bill maintenance drugs once a month for members they serve in facilities due to the manner in which the pharmacy provides the drugs to the facility e.g. weekly or every two weeks. However, the change will result in consistent billing by all pharmacies who serve the Medicaid population. The manner in which the pharmacy provides the drugs to the facility is a contractual agreement between the facility and the pharmacy serving the facility. Additionally pharmacies with automatic refill policies may oppose the requirement to develop appropriate policies regarding refill initiation.

Practitioners who prescribe medication-assisted treatment (MAT) will likely support the removal of the clinical prior authorization (PA).

6. 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.)

No.



Administrative Rule Fiscal Impact Statement

Date: July 25, 2019

Agency: Human Services
IAC citation: 441 IAC – 78 and 79
Agency contact: Susan Parker

Summary of the rule:

The rule updates and clarifies language to reflect existing prescribed outpatient drug policies for qualified prescribers, reasons for nonpayment of drugs, covered nonprescription drugs, quantity dispensed, drug reimbursement methodology (including dispensing fee limitation) and credits for returned unit dose drugs not consumed. The rule also adds language regarding initiation of refill requirements with the prohibition of automatic refills and includes legislatively required prior authorization (PA) limitations on medication-assisted treatment (MAT), including opioid overdose treatment, under the pharmacy and medical benefits.

Fill in this box if the impact meets these criteria:

- No fiscal impact to the state.
- Fiscal impact of less than \$100,000 annually or \$500,000 over 5 years.
- Fiscal impact cannot be determined.

Brief explanation:

Budget Analysts must complete this section for ALL fiscal impact statements.

Removal of clinical prior authorization (PA) for medication assisted treatment (MAT) drugs is projected to have the following impacts:

- For the Pharmacy Benefit: It is estimated removing the PA requirement would result in additional expenditures for this category of drugs. There would be increased prescribing/utilization.
- Pharmacy Benefit increased expenditures are estimated at the following: Total dollars before rebates \$80,000 (\$24,000 state share); \$35,000 net of rebates (\$10,500 state share). The state share is based on a blend between the traditional Medicaid and Iowa Health and Wellness Plan populations. This fiscal impact is a combined total for both FFS and Managed Care.
- There are no associated programming costs with this change.
- For the Medical Benefit: There is no fiscal impact as none of these drugs require a PA under the medical benefit.
- Medical Contracts: No impact projected to the Medical Contracts General Fund Appropriation.

Enforcement of the dispensing fee allowance on maintenance drugs is projected to have the following impacts:

- Clarifying the quantity prescribed and dispensing fee allowance could result in savings to the Medicaid program in cases where a pharmacy has been reimbursed greater than one dispensing fee per drug per member per month for maintenance drugs.
- The annualized savings is projected to be as follows per program based on the current dispensing fee of \$10.07 and current utilization:
 - FFS \$31,418 total (state and federal) dollars (Based on April 2019 data and annualized.)
 - Amerigroup \$336,000 (Based on April 2019 data and annualized.)
 - UnitedHealthcare \$660,965 (Based on March 2019 data and annualized.)

For both changes, PA removal and limit of one dispensing fee, the MCO cost impact is part of the capitation rate setting.

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:

- There will be increased dispensing of medication-assisted treatment (MAT) drugs with clinical prior authorization removal.
- There will be a savings attributed to limiting reimbursement of the dispensing fee for maintenance drugs to once a month. Savings was calculated based on current utilization and number of prescriptions reimbursing at greater than one dispensing fee per month.

Expenditures - Pharmacy Benefit (net of rebates) - \$35,000 (\$10,500 state share);

Savings based on dispensing fee allowance and utilization (FFS) - \$1,028,383 (\$308,515 state share)

Net impact - \$35,000 - \$1,028,383 = (\$993,383) total; (\$298,015) state share

Describe how estimates were derived:

Medical Assistance: Estimates were calculated and provided by Iowa Medicaid Enterprise and CHC – PDL vendor.

Managed Care Organizations: Amerigroup calculated their savings and Iowa Medicaid Enterprise, utilizing encounter data, calculated UnitedHealthcare savings attributed to the limit of one dispensing fee per month for maintenance drugs.

Medical Contracts: Information provided by DHS Staff.

SFY20 assumes a five month impact due to the February 2020 effective date.

Estimated Impact to the State by Fiscal Year

	Year 1 (FY 20)	Year 2 (FY 21)
Revenue by each source:		
General fund		
Federal funds	-289,737.00	-695,368.00
Other (specify):		
TOTAL REVENUE	-289,737.00	-695,368.00
Expenditures:		
General fund	-124,173.00	-298,015.00
Federal funds	-289,737.00	-695,368.00
Other (specify):		
TOTAL EXPENDITURES	-413,910.00	-993,383.00
NET IMPACT	124,173.00	298,015.00

This rule is required by state law or federal mandate.

Please identify the state or federal law:

Identify provided change fiscal persons:

The portion related to MAT coverage without a prior authorization is state mandated by 2019 Iowa House File 623.

Funding has been provided for the rule change.

Please identify the amount provided and the funding source:

Funding has not been provided for the rule.

Please explain how the agency will pay for the rule change:

The net result of these changes is a savings which has already been incorporated into the MCO capitation rates.

Fiscal impact to persons affected by the rule:

Pharmacies may be impacted if they currently do not bill a one-month supply of maintenance drugs at a time for members but rather bill several times a month. The change will result in one dispensing fee being paid rather than several.

Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):

None anticipated.

Agency representative preparing estimate: Jason Buls

Telephone number: 515-281-5764

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rule making related to case management services

The Human Services Department hereby amends Chapter 73, “Managed Care,” Chapter 78, “Amount, Duration and Scope of Medical and Remedial Services,” and Chapter 83, “Medicaid Waiver Services,” rescinds Chapter 90, “Targeted Case Management,” and adopts a new Chapter 90, “Case Management Services,” Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4.

Purpose and Summary

This rule making adopts a new Chapter 90 that clarifies the case management service activities received by various populations in the Medicaid program and includes a definition of and references to a core standardized assessment (CSA) as required under the Balancing Incentive Program (BIP). BIP was created as part of the federal Patient Protection and Affordable Care Act. Participation by Iowa is required by 2012 Iowa Acts, chapter 1133, section 14, and 2013 Iowa Acts, chapter 138, section 142(20). In addition, new Chapter 90 outlines and requires billable activities for fee-for-service members, includes a requirement for provider reporting of minor incidents, and includes the person-centered service planning definition and service requirements. Cross-reference citations in other chapters that are affected by this rule making are also updated.

Public Comment and Changes to Rule Making

The Department received 83 written comments from eight respondents regarding the proposed changes. The following persons and organizations provided written comments: Linda Duffy, Integrated Health Home Program Manager, Child Health Specialty Clinics; Sabra Rosener, J.D., Vice President of Government and External Affairs at UnityPoint

Health; Flora A. Schmidt, Executive Director, Iowa Behavioral Health Association; Jane Wollum, Administrator, Johnson County Case Management; Cynthia Pederson, J.D., state Long-term Care Ombudsman; Melissa Ahrens, Director of Integrated Programs,

Community Support Advocates; Sara Hackbart, Health Home Program Manager, Amerigroup; and Shelly Chandler, Executive Officer, Iowa Association of Community Providers.

The comments and corresponding responses from the Department are divided into 10 topic areas as follows.

1. Additional clarification needed throughout Chapter 90. Twenty-nine comments were received on this topic.

- Twenty-five comments requested clarification regarding how new 441—Chapter 90 applied to Integrated Health Home (IHH) non-intensive care management (ICM) members.

Department response: The Department has added clarifying statements for each rule. The Department has also added statements clarifying that the requirements for this chapter apply to the IHH populations of habilitation services and the children’s mental health waiver, and not to the full IHH population.

- Three comments asked to have additional words defined.

Department response: The words “applicant” and “case management” are now defined in the chapter. The Department has taken the comment to define the word “representative” under advisement, but has decided to not add the definition. “Representative” has many meanings depending upon how it is used. Leaving “representative” undefined in this chapter allows the broader meanings to all be acceptable.

- One comment requested use of the term “IHH care coordination” instead of “IHH case management.”

Department response: The term has been revised throughout the rule making.

2. Location or method of contact. Seven comments were received on this topic.

- Five comments relate to the change in location of the case manager quarterly face-to-face contact, and the restrictions involved by using face-to-face or telephonic contact as the methods of required monthly contact.

Department response: The Department has taken the suggestions under advisement, but has decided to not alter the proposed chapter. The Department strongly believes that the case manager should have more direct interaction with the member and the guardian or representative to improve knowledge of the member’s residence in order to better assess and monitor member health, safety, and welfare. Members continue to have a choice in location and method of contact that is made outside of these three required contacts.

- One comment asked the Department to specify under what circumstances the MCO contact requirements might differ from subrule 90.4(1).

Department response: The Department has taken the comment under advisement, but has decided to not alter the proposed subrule. This subrule was written without specificity to allow the Department future flexibility in managed care organization (MCO) contract negotiation.

- One comment requested the Department reinstate the prior rule language that allows for broader options of methods of communication between the member and case manager for most contacts.

Department response: The Department has taken the comment under advisement, but has decided to not alter the chapter. In regard to the quarterly face-to-face contacts and the monthly face-to-face or telephonic contacts, the Department has purposely limited the method of contact in order to increase case manager direct contact with the member and the guardian or representative. That increased direct contact should improve case manager knowledge of the member's residence in order to better assess and monitor member health, safety, and welfare. Members continue to have a choice in location and method of contact that is made outside of these three required contacts.

3. Core standardized assessments. Two comments were received on this topic.

Commenters asked for clarification in regard to whether an MCO will perform the core standardized assessment or if the MCO has the ability to transfer that responsible to another entity.

Department response: The Department has revised rule 441—90.1(249A) to state that an MCO shall either perform core standardized assessments for MCO-enrolled members or transfer the responsibility to another entity.

4. Clarification of targeted case management and the definition of the targeted population. Three comments were received on this topic.

Department response: Statements clarifying “targeted case management” and “targeted population” were added to the chapter.

5. Person-centered planning. Nineteen comments were received on this topic.

- Eight comments requested changes to the wording used in subrule 90.4(1) regarding person-centered service plans and the person-centered planning process.

Department response: The Department has taken the comment under advisement, but has decided to not alter subrule 90.4(1). The federal government has issued direction and guidance in relation to person-centered service plans and the person-centered planning process. The Department has purposefully chosen to not revise that wording other than to add the words “guardian” or “representative” when one or the other was used.

- Five comments were received regarding the person-centered planning format or tool. Requests were made to have the formats and tools identified in rule.

Department response: The Department has taken the comment under advisement, but has decided to not alter the language. The Department does not mandate or recommend any particular format or tool. If the case manager has options in either format or tool, then the member should have choice.

- One comment stated that term case manager did not apply to IHH care coordination.

Department response: The definition of “case management” in rule 441—90.1(249A) has been revised to explicitly include IHH care coordination for members participating in habilitation services and the children's mental health waiver.

- One comment requested the addition of the word “services” after any reference to HCBS.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule. HCBS is an acronym for “Home and Community Based Services.” Adding the word “services” would be redundant.

- One comment requested that numbered paragraph 90.4(1)“b”(3)(10) be removed because the commenter thought that there was no identification of the entity responsible for this paragraph.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule. Paragraph 90.4(1)“b” already identifies the case manager as the person responsible for the person-centered service plan and processes.

- One comment asked the department to designate the risk assessment tool to be used for all members.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule. The Department has purposefully chosen to allow each case management provider to choose the risk assessment tool to be used.

- One comment asked to remove redundant mention of a 365-day cycle for service plan review and revision.

Department response: The Department has taken the comment under advisement, but has decided to not alter the language. The Department has purposefully used redundant language to stress the importance of the timeframe.

- One comment requested that the Department revert to prior language regarding monitoring to use the word “may” instead of the word “shall.”

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule. The Department has purposefully revised the rule to use “shall,” as our expectation is that case managers should be reviewing provider service documentation to ensure the member is receiving services as authorized.

6. **Assessments.** Thirteen comments were received on this topic.

- Three comments asked for clarification about the use of face-to-face or telephonic reassessments.

Department response: This rule has been revised to indicate that only a Supports Intensity Scale® Assessment (SIS) can be done telephonically, and then only when the situation meets the criteria outlined by the American Association on Intellectual and Developmental Disabilities (AAIDD). An interRAI reassessment cannot be done telephonically.

- Three comments asked to add the reference for the Core Standardized Assessment used for the Habilitation population.

Department response: Clarifying statements have been added to the rule.

- One comment stated that the term “comprehensive” assessment has not been defined in the rule.

Department response: The term “comprehensive” has been removed from this rule.

- Two comments requested clarification of the statement that case managers may participate during the assessment or reassessment process at the request of the member.

Department response: The rule has been clarified. The commenters seem to believe that the participation of the case manager in the assessment allows the case manager to become the assessor. This is not true. A trained assessor will always conduct the assessment. The case manager can participate just as a family member, representative, guardian, or provider can participate if chosen by the member.

- One commenter requested the Department require that the case manager always be present unless contraindicated by the member.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule. While it is best practice that a case manager participate in the reassessment processes, the Department intends to allow member choice to take precedent.

- One commenter requested that the word “applicant” be used in conjunction with any mention of initial assessments, and that the word “member” be used in conjunction with reassessments.

Department response: The rule has been revised except for those sections where federal guidance is used for person-centered service plan and person-centered planning processes.

- One commenter suggested that the definition of core standardized assessments be moved out of the definitions section and into the body of the rule.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule.

- One commenter suggested that the department require the assessment to be sent to the Interdisciplinary Team (IDT) within 14 calendar days.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule.

7. Covered services. Three comments were received on this topic.

- One comment questioned the change in subrule 90.4(1) to require monitoring activities by the case manager. The words “as needed” appear to cause confusion.

Department response: The confusing words have been removed from the rule. Monitoring is an integral part of case management and should be done as warranted by each individual situation. There are no frequency standards for this service.

- Two comments regarding case manager monitoring of provider documentation asked the Department to change the word “shall” to the word “may.”

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule. The Department intends that case managers play a more active role in monitoring of provider documentation to gain better knowledge of the use of authorized services and of member welfare. At this time, the Department is not issuing guidance or mandates for this activity.

8. Billable activities. Two comments were received on this topic.

- One comment questioned the limited number of activities that are considered as billable activities for fee-for-service (FFS) case management (not applicable to MCO or IHH enrolled populations).

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule. Informational Letter 1394, effective 7/1/14, announced the new limited billable activities list. This list was the consensus of a case management workgroup, whose intention was to standardize billable activities in order to bring about standardization of provider rates. Billable activities were purposefully limited in order to stress the importance of completing case management activities efficiently.

- One comment suggested that the Department annually adjust the FFS case management fee schedule to allow for wage and benefit increases.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule. The Iowa legislature determines when FFS provider rates are changed. If the legislature mandates an increase, then the Department will comply.

9. **441—Chapter 24.** One comment was received on this topic.

- The commenter asked if a specific subrule of 441—Chapter 24 applied to IHH enrolled providers.

Department response: This rules package is applicable to Medicaid case management. Any questions related to 441—Chapter 24 should be addressed directly to the mental health and disability services staff.

10. **Service provider requirements.** Four comments were received on this topic.

- One comment questioned whether the proposed changes to who must report incidents were adding in types of staff responsible to report.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule. This rules change implements a requirement that has been in practice for years, and is already included in other Iowa Administrative Code rules.

- One comment expressed concern about the removal of references to appeal rights from the chapter.

Department response: The Department has taken the comment under advisement, but has decided to not alter the chapter. The Iowa Attorney General's Office advised removal of references to appeal rights because those rights are addressed under other Iowa Administrative Code rules. The intent is to avoid confusion due to this reference's inclusion in multiple rules. There is no effect on any member's appeal rights by removing these references in this chapter.

- Two comments were received in reference to use of a risk assessment and subsequent updates to the person-centered service plan based upon review of changes to the risk assessment. The commenter asked to have the updates made to a progress note or another place in the member record instead of in the service plan.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule. A progress note is not the person-centered service plan; it is merely a record of activities. The service plan drives how services are provided and is the living document used to communicate the services, or changes to services, to all providers and the others responsible for the plan.

Fiscal Impact

This rule making has no fiscal impact to the State of Iowa.

Jobs Impact

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

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rule-making actions are adopted:

ITEM 1. Amend subrule 73.5(2) as follows:

73.5(2) *Community-based case management service.* The managed care organization is required to provide services that meet requirements specified in the contract and in 441—subrule 90.5(1) Chapter 90.

ITEM 2. Amend paragraph 78.27(6)“a” as follows:

a. *Scope.* Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A) 441—90.4(249A) through 441—90.7(249A).

ITEM 3. Amend paragraph 78.37(17)“a” as follows:

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A) 441—90.4(249A) through 441—90.7(249A).

ITEM 4. Amend paragraph 78.43(1)“a” as follows:

a. Case management services shall be provided as set forth in rules ~~441—90.5(249A)~~ and ~~441—90.8(249A)~~ 441—90.4(249A) through 441—90.7(249A).

ITEM 5. Amend subparagraph **83.2(1)“d”(1)** as follows:

(1) The member’s designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in ~~rule 441—90.5(249A)~~. paragraph 441—90.4(1)“b.”

ITEM 6. Amend rule ~~441—83.7(249A)~~, introductory paragraph, as follows:
Service plan. A service plan shall be prepared for health and disability waiver members in accordance with ~~paragraph 90.5(1)“b.”~~ 441—90.4(1)“b.” Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person’s situation or condition.

ITEM 7. Amend subrule 83.22(2) as follows:

83.22(2) Need for services, service plan, and cost.

a. *Case management.* Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to rule ~~441—77.29(249A)~~. Case management services shall be provided as set forth in rules ~~441—90.5(249A)~~ and ~~441—90.8(249A)~~ 90.4(249A) through 90.7(249A).

b to d. No change.

ITEM 8. Rescind 441—Chapter 90 and adopt the following **new** chapter in lieu thereof:

CHAPTER 90
CASE MANAGEMENT SERVICES
PREAMBLE

Case management services are designed to ensure the health, safety, and welfare of members by assisting them in gaining access to appropriate and necessary medical services and interrelated social, educational, housing, transportation, vocational, and other services. The term “case management” encompasses all categories of case management: targeted case management, case management and administrative case management provided to members enrolled in a 1915(c) waiver, community-based case management provided through managed care, and integrated health home (IHH) care coordination provided to the Habilitation and Children’s Mental Health Waiver populations. If a section of this rules does not apply to all categories of case management, then the rule will clarify the affected category(s).

441—90.1(249A) Definitions.

“*Adult*” means a person 18 years of age or older on the first day of the month in which service begins.

“*Applicant*” means a person that has applied for an HCBS Waiver or Habilitation program.

“*Care coordination*” means the case management services provided by an integrated health home to members who are also receiving home- and community-based habilitation services pursuant to rule ~~441—78.27(249A)~~ or HCBS children’s mental health waiver

services pursuant to rules 441—83.121(249A) through 441—83.129(249A).

“*Case management*” means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, community-based case management provided through managed care, and integrated health home (IHH) care coordination provided to the Habilitation and Children’s Mental Health Waiver populations.

“*Case manager*” means the staff person providing all categories case management services regardless of the entity providing the service or the program in which the member is enrolled, including IHH care coordination.

“*Child*” means a person other than an adult.

“*Chronic mental illness*” means a condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. The definition of chronic mental illness and qualifying criteria are found at rule 441—24.1(225C). For purposes of this chapter, people with mental disorders resulting from Alzheimer’s disease or substance abuse shall not be considered chronically mentally ill.

“*Community-based case manager*” means the employee of a Medicaid-contracted managed care organization (MCO) who provides case management services to MCO-enrolled members.

“*Core standardized assessment*” or “*CSA*” means an assessment instrument for determining the suitability of non-institutionally based long-term services and supports for an individual. The instrument shall be used in a uniform manner throughout the state to determine an applicant’s or member’s needs for training, support services, medical care, transportation, and other services and to develop an individual service plan to address such needs. The core standardized assessment shall be performed by a contractor under the direction of the department for the fee-for-service population. MCOs shall perform core standardized assessments for MCO-enrolled members or shall delegate the responsibility for completion of assessments. 441—Chapter 83 designates the assessment and reassessment tools to be used for each HCBS waiver. 441—Chapter 78 designates the assessment and reassessment tools to be used for habilitation.

“*Department*” means the department of human services.

“*Developmental disability*” means a severe, chronic disability that is determined through professionally administered screening and evaluations and that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the age of 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: (a) self-care, (b) receptive and expressive language, (c) learning, (d) mobility, (e) self-direction, (f) capacity for independent living, and (g) economic self-sufficiency; and
5. Reflects the person’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

“*Fee-for-service member*” or “*FFS member*” means a member who is not enrolled

with a managed care organization because the member is exempt from managed care organization enrollment.

"Home- and community-based services" or *"HCBS"* means services provided pursuant to Sections 1915(c) and 1915(i) of the Social Security Act.

"Integrated health home" or *"IHH"* means a provider of health home services that is a Medicaid-enrolled provider and that is determined through the provider enrollment process to have the qualifications, systems and infrastructure in place to provide IHH services pursuant to rule 441—77.47(249A). IHH covered services and member eligibility for IHH enrollment are also governed by rule 441—78.53(249A) and the health home state plan amendment. The IHH provides care coordination services for enrolled habilitation and children's mental health waiver members.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder). Diagnosis criteria are outlined in rule 441—83.61(249A).

"Major incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69, a report of dependent adult abuse pursuant to Iowa Code section 235B.3, or a report of elder abuse pursuant to Iowa Code chapter 235F; or
6. Involves a member's location being unknown by provider staff who are responsible for protective oversight.

"Managed care organization" or *"MCO"* means the same as defined in rule 441—73.1(249A).

"Medical institution" means an institution that is organized, staffed, and authorized to provide medical care as set forth in the most recent amendment to 42 Code of Federal Regulations Section 435.1009. A residential care facility is not a medical institution.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Minor incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and that is not a major incident but that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

"Person-centered service plan" or *"service plan"* means a service plan created through the person-centered planning process, directed by the member with long-term care needs or the member's guardian or representative, to identify the member's strengths, capabilities, preferences, needs, and desired outcomes.

“Rights restriction” means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom a member may share a residence.

“Targeted case management” means case management services furnished to assist members who are part of a targeted population.

“Targeted population” means people who meet one of the following criteria:

1. An adult who is identified with a primary diagnosis of intellectual disability, chronic mental illness, or developmental disability; or
2. A child who is eligible to receive HCBS intellectual disability waiver services or HCBS children’s mental health waiver services according to 441—Chapter 83.
3. A member enrolled with a managed care organization or integrated health home is not part of the Targeted population.

441—90.2(249A) Targeted case management. Rule 90.2(249A) applies only the case management category of targeted case management and the defined targeted population.

90.2(1) Eligibility for targeted case management. A person who meets all of the following criteria shall be eligible for targeted case management:

- a. The person is eligible for Medicaid or is conditionally eligible under 441—subrule 75.1(35);
- b. The person is a member of a targeted population;
- c. The person resides in a community setting or qualifies for transitional case management as set forth in subrule 90.2(4);
- d. The person has applied for targeted case management in accordance with the policies of the provider;
- e. The person’s need for targeted case management has been determined in accordance with rule 441—90.2(249A);
- f. The person is not eligible for, or enrolled in, Medicaid managed care.

90.2(2) Determination of need for targeted case management. Assessment at least every 365 days of the need for targeted case management is required as a condition of eligibility under the medical assistance program. The targeted case management provider shall determine the member’s initial and ongoing need for service based on diagnostic reports, documentation of provision of services, and information supplied by the member and other appropriate sources. The evidence shall be documented in the member’s file and shall demonstrate that all of the following criteria are met:

- a. The member has a need for targeted case management to manage necessary medical, social, educational, housing, transportation, vocational, and other services for the benefit of the member;
- b. The member has functional limitations and lacks the ability to independently access and sustain involvement in necessary services; and
- c. The member is not receiving, under the medical assistance program or under a Medicaid managed health care plan, other paid benefits that serve the same purpose as targeted case management or integrated health home care coordination.

90.2(3) Application for targeted case management. The provider shall process an application for targeted case management no later than 30 days after receipt of the application. The provider shall refer the applicant to the department’s service unit or

mental health and disability services regions if other services outside the scope of case management are needed or requested.

a. Application process and documentation. The application shall include the member's name, the nature of the request for services, and a summary of any evaluation activities completed. For FFS members, the provider shall inform the applicant in writing of the applicant's right to choose the provider of case management services and, at the applicant's request, shall provide a list of other case management services agencies from which the applicant may choose. The provider shall maintain this documentation for at least five years.

b. Application decision for targeted case management. The case manager shall inform the applicant, or the applicant's guardian or representative, of any decision to approve, deny, or delay the service in accordance with the notification requirements at 441—subrule 7.7(1).

c. Denial of applications. The case manager shall deny an application for service when:

- (1) The applicant is not currently eligible for Medicaid;
- (2) The applicant does not meet the eligibility criteria in 441—subrule 90.2(1);
- (3) The applicant, or the applicant's guardian or representative, withdraws the application;
- (4) The applicant does not provide information required to process the application;
- (5) The applicant is receiving duplicative targeted case management or integrated health home care coordination from another Medicaid provider; or
- (6) The applicant does not have a need for targeted case management.

90.2(4) Transition to a community setting. Managed care organizations must provide transition services to all enrolled members. Fee-for-service targeted case management services may be provided to a member transitioning to a community setting during the 60 days before the member's discharge from a medical institution when the following requirements are met:

a. The member is an adult who qualifies for targeted case management and is a member of a targeted population. Transitional case management is not an allowable service for other HCBS programs or populations;

b. Case management services shall be coordinated with institutional discharge planning, but shall not duplicate institutional discharge planning;

c. The amount, duration, and scope of case management services shall be documented in the member's service plan, which must include case management services before and after discharge, to facilitate a successful transition to community living;

d. Payment shall be made only for services provided by Medicaid-enrolled targeted case management providers; and

e. Claims for reimbursement for case management services shall not be submitted until the member's discharge from the medical institution and enrollment in community services.

441—90.3(249A) Termination of targeted case management services. Rule 90.3(249A) applies only the case management category of targeted case management and the defined targeted population.

90.3(1) Targeted case management shall be terminated when:

- a. The member does not meet eligibility criteria under rule 441—90.2(249A);
- b. The member has achieved all goals and objectives of the service;
- c. The member has no ongoing need for targeted case management;
- d. The member is receiving targeted case management based on eligibility under an HCBS program but is no longer eligible for the program;
- e. The member or the member's guardian or representative requests termination;
- f. The member is unwilling or unable to accept further services; or
- g. The member or the member's guardian or representative fails to provide access to information necessary for the development of the service plan or for implementation of targeted case management.

90.3(2) The provider shall notify the member or the member's guardian or representative in writing of the termination of targeted case management, in accordance with 441—subrule 7.7(1).

441—90.4(249A) Case management services. Rule 90.4(249A) applies to all categories of case management and all populations covered by case management.

90.4(1) Covered services. The following shall be included in case management services provided to members, whether FFS members or MCO-enrolled members:

a. *Assessment.* Initial assessments and regular reassessments must be done for each applicant and member to determine the need for any medical, social, educational, housing, transportation, vocational, or other services. The assessments and reassessments shall address all of the applicant's and member's areas of need, strengths, preferences, and risk factors, considering the person's physical and social environment. Applicants and members will receive individualized prior notification of the assessment tool to be used and of who will conduct the assessment. The assessment and reassessment will be done using the core standardized assessment or another tool as designated in 441—Chapter 83 for each waiver population and 441—Chapter 78 for the habilitation population. Initial assessments must be face to face. Reassessments using the interRAI must be done face to face. Only the Supports Intensity Scale assessment can be done telephonically, and then only when the situation meets the criteria outlined by the American Association on Intellectual and Developmental Disabilities (AAIDD). The off year assessment (OYA) done for the intellectual disability waiver can be done telephonically. A reassessment must be conducted at a minimum every 365 days and more frequently if material changes occur in the member's condition or circumstances. Case managers may participate during the assessment or reassessment process at the request of the applicant or member; the case manager does not assume the role of the assessor.

b. *Person-centered service plan.* At least every 365 days, the case manager shall develop and revise a comprehensive, person-centered service plan in collaboration with the member, the member's service providers, and other people identified as necessary by the member, as practicable. The person-centered service plan will be developed based on the assessment and shall include a crisis intervention plan based on the risk factors identified in a risk assessment. The case manager shall document the member's history, including current and past information and social history, and shall update the history annually. The case manager shall gather information from other sources such as family members, medical providers, social workers, representatives, and others as necessary to

form a thorough social history and comprehensive person-centered service plan with the member. The person-centered service plan may also be referred to as a person-centered treatment plan.

(1) The person-centered service plan shall address all service plan components outlined in this chapter and in 441—Chapter 83 for the waiver in which the member is enrolled or 441—Chapter 78 for members enrolled in habilitation.

(2) Person-centered planning shall be implemented in a manner that supports the member, makes the member central to the process, and recognizes the member as the expert on goals and needs. In order for this to occur, there are certain process elements that must be included in the process. These include:

1. The member, guardian or representative must have control over who is included in the planning process, as well as have the authority to request meetings and revise the person-centered service plan (and any related budget) whenever reasonably necessary.

2. The process is timely and occurs at times and locations of convenience to the member, the member's guardian, representative and family members, and others, as practicable.

3. Necessary information and support are provided to ensure that the member or the member's guardian or representative, are central to the process and understand the information. This includes the provision of auxiliary aids and services when needed for effective communication.

4. A strengths-based approach to identifying the positive attributes of the member shall be used, including an assessment of the member's strengths and needs. The member should be able to choose the specific planning format or tool used for the planning process.

5. The member's personal preferences shall be considered to develop goals and to meet the member's HCBS needs.

6. The member's cultural preferences must be acknowledged in the planning process, and policies/practices should be consistent with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) of the Office of Minority Health, U.S. Department of Health and Human Services.

7. The planning process must provide meaningful access to members and their guardians or representatives with limited English proficiency (LEP), including low literacy materials and interpreters.

8. Members who are under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, must have the opportunity in the planning process to address any concerns.

9. There shall be mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines.

10. Members shall be offered information on the full range of HCBS available to support achievement of personally identified goals.

11. The member or the member's guardian or representative shall be central in determining what available HCBS are appropriate and will be used.

12. The member shall be able to choose between providers or provider entities, including the option of self-directed services when available.

13. The person-centered service plan shall be reviewed at least every 365 days or

sooner if the member's functional needs change, circumstances change, or quality of life goals change, or at the member's request. There shall be a clear process for members to request reviews. The case management entity must respond to such requests in a timely manner that does not jeopardize the member's health or safety.

14. The planning process should not be constrained by any case manager's or guardians or representative's preconceived limits on the member's ability to make choices.

15. Employment and housing in integrated settings shall be explored, and planning should be consistent with the member's goals and preferences, including where the member resides and with whom the member lives.

(3) Elements of the person-centered service plan. The person-centered service plan shall identify the services and supports that are necessary to meet the member's identified needs, preferences, and quality of life goals. The person-centered service plan shall:

1. Reflect that the setting where the member resides is chosen by the member. The chosen setting must be integrated in, and support full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS.

2. Be prepared in person-first singular language and be understandable by the member or the member's guardian or representative.

3. Note the strengths-based positive attributes of the member at the beginning of the plan.

4. Identify risks, while considering the member's right to assume some degree of personal risk, and include measures available to reduce risks or identify alternate ways to achieve personal goals.

5. Document goals in the words of the member or the member's guardian or representative, with clarity regarding the amount, duration, and scope of HCBS services that will be provided to assist the member. Goals shall consider the quality of life concepts important to the member.

6. Describe the services and supports that will be necessary and specify what HCBS services are to be provided through various resources, including natural supports, to meet the goals in the person-centered service plan.

7. Document the specific person or persons, provider agency and other entities providing services and supports.

8. Ensure the health and safety of the member by addressing the member's assessed needs and identified risks.

9. Document non-paid supports and items needed to achieve the goals.

10. Include the signatures of everyone with responsibility for the plan's implementation, including the member or the member's guardian or representative, the case manager, the support broker/agent (when applicable), and providers, and include a timeline for review of the plan. The plan must be discussed with family, friends, and caregivers designated by the member so that they fully understand it and their roles.

11. Identify each person and entity responsible for monitoring the plan's implementation.

12. Identify needed services based upon the assessed needs of the member and prevent unnecessary or inappropriate services and supports not identified in the assessed needs of

the member.

13. Document an emergency back-up plan that encompasses a range of circumstances (e.g., weather, housing, and staff).

14. Address elements of self-direction through the consumer choices option (e.g., financial management service, support broker/agent, alternative services) whenever the consumer choices option is chosen.

15. Be distributed directly to all parties involved in the planning process.

c. Referral and related activities. The case manager shall assist, as needed, the member in obtaining needed services, such as by scheduling appointments for the member and by connecting the member with medical, social, educational, housing, transportation, vocational or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the person-centered service plan.

d. Monitoring and follow-up. The case manager shall perform monitoring activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the person-centered service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home, when applicable), and all services regardless of the service funding stream. Monitoring shall also include review of service provider documentation. Monitoring of the following aspects of the person-centered service plan shall lead to revisions of the plan if deficiencies are noted:

(1) Services are being furnished in accordance with the member's person-centered service plan, including the amount of service provided and the member's attendance and participation in the service;

(2) The member has declined services in the service plan;

(3) Communication among providers is occurring, as practicable, to ensure coordination of services;

(4) Services in the person-centered service plan are adequate, including the member's progress toward achieving the goals and actions determined in the person-centered service plan; and

(5) There are changes in the needs or circumstances of the member. Follow-up activities shall include making necessary adjustments in the person-centered service plan and service arrangements with providers.

e. Contacts. Case managers shall make contacts with the member, the member's guardian or representative, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements:

(1) The case manager shall have at least one face-to-face contact with the member in the member's residence at least quarterly;

(2) The case manager shall have at least one contact per month with the member or the member's guardian or representative. This contact may be face to face or by telephone;

(3) Community-based case management contacts will be made in accordance with the Medicaid contract MED-16-019, or subsequent Medicaid managed care contracts with the department, in those instances where the contract specifies contacts different from this rule.

90.4(2) Exclusions. Payment shall not be made for activities otherwise within the definition of case management services when any of the following conditions exist:

a. The activities are an integral component of another covered Medicaid service.
b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred. Such services include, but are not limited to:

- (1) Services under parole and probation programs;
- (2) Public guardianship programs;
- (3) Special education programs;
- (4) Child welfare and child protective services; or
- (5) Foster care programs.

c. The activities are components of the administration of foster care programs, including but not limited to the following:

- (1) Research gathering and completion of documentation required by the foster care program;
- (2) Assessing adoption placements;
- (3) Recruiting or interviewing potential foster care parents;
- (4) Serving legal papers;
- (5) Conducting home investigations;
- (6) Providing transportation related to the administration of foster care;
- (7) Administering foster care subsidies; or
- (8) Making placement arrangements.

d. The activities for which a member may be eligible are a component of the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

e. The activities duplicate institutional discharge planning.

441—90.5(249A) Rights restrictions. Rule 90.5(249A) applies to all categories of case management and all populations covered by case management. Any effort to restrict the rights of a member to realize the member's preferences or goals must be justified by a specific individualized assessed safety need and documented in the person-centered service plan. The following requirements must be documented in the plan when a safety need has been identified that warrants a rights restriction:

1. The specific and individualized assessed safety need;
2. The positive interventions and supports used prior to any modifications or additions to the person-centered service plan regarding safety needs;
3. The less intrusive methods of meeting the safety needs that have been tried but were not successful;
4. A clear description of the rights restriction that is directly proportionate to the specific assessed safety need;
5. The regular collection and review of data to measure the ongoing effectiveness of the rights restriction;
6. The established time limits for periodic reviews to determine whether the rights restriction is still necessary or can be terminated;

7. The informed consent of the member to the proposed rights restriction; and
8. An assurance that the rights restriction itself will not cause undue harm to the member.

441—90.6(249A) Documentation and billing.

90.6(1) *Documentation of contacts.* Rule 90.6(1) applies to all categories of case management and all populations covered by case management.

a. Documentation of case management services contacts shall include:

- (1) The name of the individual case manager;
- (2) The need for, and occurrences of, coordination with other case managers within the same agency or referral or transition to another case management agency; and
- (3) Other requirements as outlined in rule 441—79.3(249A) to support payment of services.

b. Targeted case management providers serving FFS members must also adhere to 441—subrule 24.4(4).

90.6(2) *Rounding units of service for case management services.* Rule 90.6(2) applies only to Targeted Case management provided to FFS members or case management provided to FFS brain injury waiver and FFS elderly waiver members. For all fee-for-service case management units of service, the following rounding process shall be used:

a. Add together the minutes spent on all billable activities during a calendar day for a daily total;

b. For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day;

c. Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit; and

d. Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

90.6(3) *Collateral contacts.* Rule 90.6(3) applies only to Targeted case management provided to FFS members or case management provided to FFS Brain Injury Waiver and FFS Elderly Waivers members. For all fee-for-service case management units of service, the case manager may bill for documented contacts with other entities and individuals if the contacts are directly related to the member's needs and care, such as helping the member access services, identifying needs and supports to assist the member in obtaining services, providing other case managers with useful feedback, and alerting other case managers to changes in the member's needs.

90.6(4) *Billable activities for case management services.* Rule 90.6(4) applies only to Targeted Case management provided to FFS members or case management provided to Brain Injury or Elderly Waivers FFS members. Billable activities for case management services are limited to the following activities, and any activity included in this list must be billed if the activity has occurred.

a. Face-to-face meeting with the member:

- (1) Contact time; and
- (2) Documentation completed during meeting.

b. Telephone conversation with the member:

- (1) Contact time; and

- (2) Documentation completed during meeting.
- c. Collateral contacts on behalf of the member, including face-to-face, the telephone, and email contacts:
 - (1) Contact time; and
 - (2) Documentation completed during meeting.
- d. Individual care plans and person-centered service plans:
 - (1) Creation; and
 - (2) Revision.
- e. Social histories:
 - (1) Creation; and
 - (2) Revision.
- f. Assessments and reassessments:
 - (1) Participation during the assessment if requested by the member; and
 - (2) Utilization of the assessment for creation of the person-centered service plan.

441—90.7(249A) Case management services provider requirements. Rule 90.7(249A) applies to all categories of case management and all populations covered by case management.

90.7(1) Reporting procedures for major incidents.

a. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member shall notify the following persons of the incident by midnight of the next calendar day after the incident:

- 1. The staff member's supervisor;
- 2. The member or member's legal guardian; and
- 3. The member's case manager. The case manager shall create an incident report if a provider has not submitted a report.

(2) By midnight of the next business day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known by the staff member about the incident to the member's managed care organization in the format required by the managed care organization. If the member is not enrolled with a managed care organization, or is receiving money follows the person funding, the staff member shall report the information by direct data entry into the Iowa Medicaid portal access (IMPA) system. The case manager is responsible for reporting the incident if the provider of service has not already reported the incident.

(3) The following information shall be reported:

- 1. The name of the member involved;
- 2. The date, time, and location where the incident occurred;
- 3. A description of the incident;
- 4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other Medicaid-eligible members or non-Medicaid-eligible persons who were present must be maintained by the use of initials or other means;
- 5. The action taken to manage or respond to the incident;
- 6. The resolution of or follow-up to the incident; and
- 7. The date the report is made and the handwritten or electronic signature of the

person making the report.

(4) When complete information about the incident is not available at the time of the initial report, the case management services provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up.

(5) The case management services provider shall maintain the completed report in a centralized file with a notation in the member's file.

(6) The case management services provider shall track incident data and analyze trends to assess the health and safety of members served and to determine whether changes need to be made for service implementation or whether staff training is needed to reduce the number or severity of incidents.

b. When an incident report for a major incident is received from any provider, the case manager shall monitor the situation to ensure that the member's needs continue to be met.

c. When any major incident occurs, the case manager shall reevaluate the risk factors identified in the risk assessment portion of the service plan in order to ensure the continued health, safety, and welfare of the member. Documentation must be made in the person-centered service plan of this review and follow-up activities.

90.7(2) Reporting procedures for minor incidents. Minor incidents may be reported in any format designated by the case management services provider. When a minor incident occurs, or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member's file.

90.7(3) Quality assurance. Case management services providers shall cooperate with quality assurance activities conducted by the Iowa Medicaid enterprise or a Medicaid managed care organization, as well as any other state or federal entity with oversight authority to ensure the health, safety, and welfare of Medicaid members. These activities may include, but are not limited to:

- a. Postpayment review of case management services;
- b. Review of incident reports;
- c. Review of reports of abuse or neglect; and
- d. Technical assistance in determining the need for service.

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

Comments and Responses on ARC 4739C
Case Management Services
Received November 2019

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

1. Linda Duffy, IHH Program Manager, Child health Specialty Clinics
2. Sabra Rosener, JD, VP Government & External Affairs, Unity Point
3. Flora A. Schmidt, Iowa Behavioral Health Association
4. Jane Wollum, Johnson County
5. Cynthia Pederson, JD, state Long-term Care Ombudsman
6. Melissa Ahrens, Director of Integrated Programs, Community Support Advocates
7. Sara Hackbart, Health Home Program Manager, Amerigroup
8. Shelly Chandler, Executive Office, Iowa Association of Community Providers

The Department received 83 comments from eight respondents on the proposed rules. The comments and corresponding responses from the Department are divided into 10 topic areas as follows:

COMMENT:

A. Additional clarification needed throughout the chapter. There were 29 comments in this topic area.

1. 25 comments requested clarification of how this chapter applied to Integrated Health Home non-ICM members.

Department response: The Department has added clarifying statements for each rule. The Department has also added clarifying statements that the requirements for this chapter apply to the IHH populations of Habilitation and Children's Mental Health Waiver, and not to the full IHH population.

2. Three comments asked to have the additional words defined.

Department response: The word 'applicant' is now defined in the rule. The term 'case management' is now defined in the rule. The word 'representative' was not added as the word has many meanings depending upon how it is used. Left undefined in this rule allows the broader meanings to all be acceptable. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

3. One comment requested use of the term 'IHH Care Coordination' instead of 'IHH case management'.

Department response: The revision has been made throughout the rule.

B. Location or method of contacts. Seven comments were received on this topic.

1. Five comments are in relation to the change in location of the case manager quarterly face to face contact, and the restrictions to face to face or telephonic as the methods of contact for the required monthly contacts.

Department response: The Department believes strongly that the case manager should have more direct interaction with the member and guardian or representative, to improve knowledge of the member's residence in order to better assess and monitor member health, safety, and welfare. Members continue to have a choice in location and methods of contacts that are made outside of these three required contacts. The Department has taken the suggested under advisement but has decided to not alter the proposed rule.

2. One comment asked the Department to specify what circumstances would lead to instances where the MCO contacts requirements might differ from these rules.

Department response: This rule was written without specificity to allow the Department future flexibility in MCO contract negotiation. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

3. One comment requested the Department to put back the prior rule language that allows for a broader options for methods of communication between the member and case manager for most contacts.

Department response: For the quarterly face to face contacts and the monthly face to face or telephonic contacts the Department has purposely limited the method of contacts in order to increased case manager direct contact with the member. That increased direct contact should improve case manager knowledge of the member's residence in order to better assess and monitor member health, safety, and welfare. Members continue to have a choice in location and methods of contacts that are made outside of these three required contacts. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

C. Core Standardized Assessments. Two comments were received.

Commenters asked for clarification whether the MCO will perform the assessment or if they have the ability to transfer that responsible to another entity.

Department response: The Department has revised the rule to indicate that the MCO will cause the assessment to be completed for MCO-enrolled members. This allows the MCO the flexibility to perform the assessment itself or to transfer the responsibility to another entity. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

D. Clarification of Targeted Case Management and of the definition of the targeted population. Three comments were received for this topic

Department response: Clarifying statements were added to the proposed rules.

E. Person Centered Planning. 19 comments received.

1. Eight comments requested changes to the wording used in the various subrules under Person Centered Plan and Person Centered Planning process.

Department response: The federal government has issued direction and guidance in relation to person centered plan and person centered planning. The

Department has purposefully chosen to not revise that wording, other than to add the words 'guardian' or 'representative' when one or the other was used. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

2. Five comments were received regarding the person centered planning format or tool. Requests were to have the formats and tools identified in rule.

Department response: The Department does not mandate or recommend any particular format or tool. If the case manager has options in either format or tool, then the member should have choice. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

3. One comment stated that term case manager did not apply to IHH care coordination.

Department response: The definition of case management has been revised to explicitly include IHH care coordination for members of Habilitation and Children's Mental Health Waiver.

4. One comment requested adding the word 'services' after any reference to HCBS.

Department response: HCBS is an acronym for Home and Community Based Services. Adding the word 'services' would be redundant. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

5. One comment asked to strike 90.4(1)b(3)10 because the commenter thought that there was no identification of the entity responsible for this section.

Department response: 90.4(1)b already identifies the case manager as the person responsible for the person-centered service plan and processes. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

6. One comment asked the Department to designate the risk assessment tool to be Used for all members.

Department response: The Department has purposefully chosen to allow each case management provider to choose the risk assessment tool to be used. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

7. One comment asked to remove redundant mention of a 365 day cycle for service planning.

Department response: The Department has purposefully used redundant language to stress the importance of the timeframe. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

8. One comment requested that the Department revert to prior language regarding monitoring to use the word 'may' instead of the word 'shall'.

Department response: The Department has purposefully revised the rule to use 'shall', as our expectation is that case managers should be reviewing provider service documentation to ensure the member is receiving services as authorized. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

F. Assessments. 13 comments were received on this topic.

1. Three comments asked for clarification about the use of face to face or telephonic reassessments.

Department response: This rule has been revised to indicate that only a SIS can be done telephonically and then only when the situation meets the criteria outlined by AAIDD. An interRAI reassessment cannot be done telephonically.

2. Three comments asked to add the reference for the Core Standardized Assessment used for the Habilitation population.

Department response: Clarifying statements have been added to the rule.

3. One comment stated that the term 'comprehensive' assessment has not been defined in the rule.

Department response: The term 'comprehensive' has been removed from this rule.

4. Two comments requested clarification of the statement that case managers may participate during the assessment or reassessment process at the request of the member.

Department response: The commenters seem to believe that the participation of the case manager in the assessment allows the case manager to become the assessor. This is not true. A trained assessor will always conduct the assessment. The case manager can participate just as a family member, representative, guardian, or provider can participate if chosen by the member. The rule has been clarified.

5. One commenter requested that the Department require that the case manager always be present unless contraindicated by the member.

Department response: While it is best practice that a case manager participate in the reassessment processes, the Department intends to allow member choice to take precedent. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

6. One commenter requested that the word 'applicant' be used in conjunction with any mention of initial assessments; and that the word 'member' be used in conjunction with reassessments.

Department response: The rule has been revised, except for those sections where federal guidance is used for person centered plan and person centered planning processes.

7. One commenter suggested that definition of Core Standardized Assessments be moved out of definitions and to the body of the rule.

Department response: The Department has taken the comment under advisement but has decided to not alter the proposed rule.

8. One commenter suggested that the Department require the assessment to be sent to the IDT within 14 calendar days.

Department response: The Department has taken the comment under advisement but has decided to not alter the proposed rule.

G. Covered Services. Three comments received on this topic.

1. One commenter questioned the change in rule to require monitoring activities by the case manager. The words 'as needed' appears to cause confusion.

Department response: The confusing words have been removed from the proposed rule. Monitoring is an integral part of case management and should be done as warranted by each individual situation. There are no frequency standards for this service. The Department has taken the suggested under advisement but has decided to not alter the proposed rule.

2. Two comments regarding case manager monitoring of provider documentation asked the Department to change the word 'shall' to the word 'may'.

Department response: The Department intends that case managers have a more active role in monitoring of provider documentation to gain better knowledge of the use of authorized services and of member welfare. At this time the Department is not issuing guidance or mandates for this activity. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

H. Billable activities. Two comments were received on this topic.

1. One comment questioned the limited number of activities that are considered as billable activities for FFS case management (not applicable to MCO or IHH enrolled populations.)

Department response: Informational Letter 1394, effective 7/1/14, announced the new limited billable activities list. This list was the consensus of a case management workgroup, whose intention was to standardize billable activities in order to bring about standardization of provider rates. Billable activities were purposefully limited in order to stress the importance of completing case management activities efficiently. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

2. One comment suggested that the Department adjust the FFS case management fee schedule annually to allow for wage and benefit increases.

Department response: The Iowa legislature determines when FFS provider rates are changed. If the legislature mandates an increase, then the Department will comply. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

J. 441-Chapter 24. One comment was received for this topic.

The commenter asked if a specific subrule of 441-Chapter 24 applied to IHH enrolled providers.

Department response: This rules package is applicable to Medicaid case management. Any questions related to Chapter 24 should be address directly to the Mental Health and Disabilities Services staff.

I. Service provider requirements. Four comments were received on this topic.

1. One comment questioned whether the proposed changes to who must report incidents was adding in types of staff responsible to report.

Department response: This rule change implements a requirement that has been in practice for years and is already included in other Iowa Administrative Code rules. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

2. One comment was concerned about the removal from this Chapter of references to appeal rights.

Department response: The Iowa Attorney General's office advised removal of reference to appeal rights as those rights are addressed under other Iowa Administrative Code rules. The intent is to avoid confusion due to inclusion in multiple rules. There is no effect on any member's appeal rights by removing references from this Chapter. The Department has taken the comment under advisement but has decided to not alter the proposed rule.

3. Two comments were received in reference to use of a risk assessment and subsequent updates to the person centered service plan based upon review of changes to the risk assessment. The commenter asked to have the updates made to a progress note or another place in the member record instead of the service plan.

Department response: A progress note is not the person centered service plan; it is merely a record of activities. The service plan drives how services are provided and is the living document used to communicate the services, or changes to services, to all providers and the others responsible for the plan. The Department has taken the comment under advisement but has decided to not alter the proposed rule.



Iowa Department of Human Services
Information on Proposed Rules

Name of Program Specialist
Leann Howland

Telephone Number
515-256-4642

Email Address
lhowlan@dhs.state.ia.us



1. Give a brief purpose and summary of the rulemaking:

- Amends the name of the Chapter from 'Targeted Case Management' to "Case Management Services". Clarifies that the term "case management services" will refer to activities and supports provided through Case Management, Targeted Case Management, Community Based Case Management, and Integrated Health Home (IHH) Care Coordination.
- These changes define the case management services activities received by various populations under the Medicaid program.
- Consolidates all references to Targeted Case Management to flow consecutively rather than being dispersed throughout the chapter.
- Revises IAC to include definition and references to Core Standardized Assessments (CSA) as required under the Balancing Incentive Payment Program (SIPP). The SIPP was created pursuant to section 10202 of the federal Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152). Participation by Iowa is required by 2012 Iowa Acts, chapter 1133, section 14, and by 2013 Iowa Senate File 446, section 142(20), including provision of "core standardized assessment instruments."
- Adds a section to outline and require billable activities for fee for service members.
- Adds a section to outline and require 15-minute unit rounding rules for fee for service members.
- Adds a requirement for provider internal reporting of minor incidents.
- Adds the person-centered service planning definition and requirements as required by the Code of Federal Regulations at 42 C.F.R. §§ 441.301(b)(1)(i), (c)(1)-(3) and 441.725
- Updates chapter 90 rules citations in other IAC chapters that are affected by this rules package.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

- Iowa Code sec. 249A.4
- 2012 Iowa Acts, chapter 1133, section 14, and 2013 Iowa Senate File 446, section 142(20)
- 42 C.F.R §§ 441.301(b)(1)(i), (c)(1)-(3) and 441.725
- Iowa 2013 Senate File 446, section 12(19)(a)(8) and section 142(18)(a)

3. Describe who this rulemaking will positively or adversely impact.

- IHH: There will be no effect on providers or members in regards to the IHH references as these provisions codify policies already followed by IHH providers pursuant to 441-IAC 77.47 and 78.53.
- CSA and SIPP: CSA was implemented in 2016 and is in rule in Chapter 83.
- Billable activities: will cause case management service providers to revise their internal processes to adhere to this rule. The activities list was announced in IL 1394 but had not yet been put into rule.
- Rounding rules: case management service providers already effectuated this change beginning 7/1/13.
- Minor incidents: All 1915(c) and 1915(i) members are subject to internal minor incident reports. This requirement has already been implemented by other HCBS providers as included in IAC Chapter 77. This revision is putting into rule what has already been common practice for case managers.
- Case management service providers are required to actively engage the members and those the members choose in developing a comprehensive person-center service plan or treatment plan. The member will benefit because they will be driving the person-centered planning process. The individual identifies planning goals to achieve those personal outcomes in collaboration with those that the

individual has identified including medical, clinical, vocational, direct service and other professional staff.

4. Does this rule contain a waiver provision? If not, why?

These amendments do not contain waiver provisions because Medicaid has determined that the same rules should be applicable to all members and providers who are eligible and because Individual members or providers may request a waiver under the Department's general rule on exceptions at IAC 441--1.8.

5. What are the likely areas of public comment?

- Comments may be received for a variety of reasons, but most of the items included in this revision are either already included in a State Plan Amendment (IHH Care Coordination), are part of the Balanced Incentive Payment (BIP for Core Standardized Assessment), are contained in the MCO contract, or have been in practice without rule.
- The case management service entities will comment on the Case Management Billable Activities list. IME issued IL 1394 on June 6, 2014 to announce upcoming rules changes.

6. 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.)

- No, these changes should not cause any impact on jobs or employment opportunities.



Administrative Rule Fiscal Impact Statement

Date: May 14, 2019

Agency: Human Services
IAC citation: 441 IAC Chapter 90
Agency contact: Leann Howland

Summary of the rule:

Medicaid program case management services, including use of Core Standardized Assessments or other assessment tools, incident reporting requirements, appeals to the Department, rounding rules and billable case management service activities, person centered service planning, and parameters of Targeted Case Management.

Fill in this box if the impact meets these criteria:

No fiscal impact to the state.

- Fiscal impact of less than \$100,000 annually or \$500,000 over 5 years.
- Fiscal impact cannot be determined.

Brief explanation:

Budget Analysts must complete this section for ALL fiscal impact statements.

There is no expected fiscal impact as most of the items included in this revision are either already included in a State Plan Amendment (IHH Care Coordination), are part of the Balanced Incentive Payment (BIP for Core Standardized Assessment), are contained in the MCO contract, or have been in practice without rule. It also does not change unit calculations or rate methodologies.

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 (FY 2020)	Year 2 (FY 2021)
Revenue by each source:		
General fund	_____	_____
Federal funds	_____	_____
Other (specify):	_____	_____
TOTAL REVENUE		_____
Expenditures:		
General fund	_____	_____
Federal funds	_____	_____
Other (specify):	_____	_____
TOTAL EXPENDITURES		_____
NET IMPACT	_____	_____

c>,j This rule is required by state law or federal mandate.

Please identify the state or federal law:

Identify provided change fiscal persons:

Iowa Code sec. 249A.4

2012 Iowa Acts, chapter 1133, section 14, and 2013 Iowa Senate File 446, section 142(20)

42 C.F.R. §§ 441.301(b)(1)(i), (c)(1)-(3) and 441.725

Iowa 2013 Senate File 446, section 12(19)(a)(8) and section 142(18)(a)

D Funding has been provided for the rule change.

Please identify the amount provided and the funding source:

c>,j Funding has not been provided for the rule.

Please explain how the agency will pay for the rule change:

There is no expected fiscal impact.

Fiscal impact to persons affected by the rule:

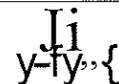
There is no expected fiscal impact.

Fiscal impact to counties or other local governments (required by Iowa Code 258.6):

No fiscal impact.

Agency representative preparing estimate: Jason Buis

Telephone number: _____ 515-281-5764



HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

The Human Services Department hereby amends Chapter 81, "Nursing Facilities," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4.

Purpose and Summary

The Department adopts these amendments in order to provide clarification on the treatment of depreciation when a change of nursing facility ownership occurs. The amendments also clarify leasing arrangements, update the Iowa Medicaid Enterprise (IME) mailing address, and make changes to reflect current operations of the IME.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on November 6, 2019, as **ARC 4740C**.

The Department received 34 comments from four respondents on the proposed rules.

1. Four respondents asked about the intent of the Iowa Medicaid Enterprise (IME) in changing the lease rule. The Provider Cost Audit and Rate Setting Unit worked with IME Policy Staff and the Attorney General's office on the intent of the Nursing Facility leasing rules. It was determined that the rule should be updated to more clearly present the intent of the rule and clearly identify allowable lessor cost.
2. Two respondents commented asking if the IME can clearly identify acceptable sources for reporting Landlord Costs. The rule change identified allowable landlord costs. Acceptable sources for these costs would be documentation that can be provided to support the amounts being reported.
3. Two respondents commented there are specific examples where the landlord may not maintain information on a specific property when it is part of a larger group of properties. The respondents asked for additional information be provided on this topic in the Provider Manual.
4. Three respondents commented asking if the Department can provide an initial schedule or form for each of their clients impacted by this rule change and use historical data to populate the form. The Department will not be providing such a form as it does not have access to all historical data.
5. Three respondents commented asking if providers will be informed of amounts the IME has determined to be allowable, and if so, at what date will that information be given to providers. Providers are responsible for supporting cost information included on the Financial and Statistical Report. If adjustments are made to reimbursable cost, by IME, those adjustments will be sent to the provider for review, as is the current procedure.

6. Two respondents commented the historical basis only references depreciable fixed assets. The respondents asked if the value of the land or other assets can be used in the calculation. The question seems to be related to the calculation of a Reasonable rate of Return. The rule says “. . .historical cost of the facility...” This can include land at its historical cost but would not include other assets.
7. Two respondents commented that in the past some landlord companies have preferred to not provide their cost information directly to the tenant. The respondents asked if there has been consideration for a separate reporting procedure for the non-related party lessors to transmit their cost information to IME.
8. Three respondents commented about the verbiage used of “tax cost” and asked what the definition of tax cost is, what the impact of using tax cost would be, and if there would be additional record keeping requirements related to using tax cost. The use of tax cost in 441 Iowa Admin. Code 81.6(11) was not changed in this rule and there is no change to current usage. This is the historical cost of an asset and depreciation is to be calculated based on the straight-line basis. Therefore, there is no impact on providers and there are no additional schedules that need to be created.
9. One respondent commented asking if there is no existing determination of the financial impact to providers, will the Department consider delaying the effective date until that determination can be made. There have been no discussions on delaying the rule change.
10. One respondent commented on the area of reporting and the providers potentially impacted have limited access to historical information that may be necessary to comply with the changes. The analysis of the underlying information can be very complex and labor intensive. The respondent asked if the rule changes can be delayed until the specific providers are identified and the potential impact determined. There have been no discussions on delaying the rule change. If a provider has been through a change of Ownership and/or leases the facility where services are provided they may be impacted.
11. One respondent commented asking if DHS can clarify how the treatment of depreciation will change following a change of ownership. The treatment of depreciation following a change of ownership should not change. The asset cost basis and depreciation for assets purchased by the previous owner are carried forward to the new owner. The new owner has been limited to the previous owner’s cost basis in the asset (historical cost). In the case where multiple change of ownerships have occurred, the original owner’s basis in the asset continues to be carried forward and determines the allowable depreciation on the Finance and Statistical Report.
12. One respondent commented asking how many providers DHS estimates could be impacted by the proposed rule changes. If a provider has been through a change of ownership and or leases the facility where services are provided, they may be impacted. Based on the Fiscal Year 2018 Financial and Statistical Reports, there were 146 providers that had some amount of lease expense reported on Schedule C line 87 (Facility Lease), column 1 (Expenses per the General Ledger). Some of these providers may be leasing space other than the facility where services are provided.
13. One respondent commented asking of the rule changes impact both related party leases and non-related party leases. Both related party and non-related party leasing arrangements would be impacted.
14. One respondent commented asking what changes to the annual cost report would need to be implemented. It is not anticipated that any changes to the Financial and Statistical Report are necessary based solely on the rule change.
15. One respondent commented asking what changes to the Provider Manual for cost reporting would be necessary. The Provider Manual will be updated for the rule changes.
16. One respondent commented asking if the IME will provide instructions detailing the information that would be required from the prior owner and the new owner based on these rule changes. Providers are responsible for being able to support all cost information that is included on the Financial and Statistical Report.

17. One respondent commented asking if the provisions in the rule change will apply to all providers, including those in other cost-based programs, and not just leased facilities in the nursing facility program. This rule change is only for the Nursing Facility program.

18. One respondent commented his clients are concerned the use of historical basis as a source of the calculation will not represent the full capital investment of the current property owners, especially those who have undergone physical renovation. Any depreciation on improvements or capital assets purchased by the lessor can be allowable depreciation. The cost basis of the items purchased through a change of ownership must be reported and depreciation based on the historical cost of the property in the hands of the original owner when the facility entered the Medicaid program. This does not change with the rule; however, providers should ensure capital assets that have changed hands through a change in ownership are reporting depreciation this way.

19. One respondent commented asking if the IME intends to send information or instructional letters limited to those providers which may be impacted by the rule change. The IME does not intend to send information or instructional letters to only those providers that are impacted. If a provider has been through a change of ownership and or leases the facility where services are provided, they may be impacted. The IME does intend to send a general informational letter about the rule change.

20. One respondent commented asking if the IME is proposing a method or some type of forum for the affected landlords and facility operators to work together to develop a timeline of information reporting for the calculation of provider payment rates. A forum for affected landlords and providers has not been discussed.

No changes from the Notice have been made.

Adoption of Rule Making

This rule making was adopted by the Human Services Department on January 8, 2020.

Fiscal Impact

Without having all of the lessors financial data relating to ownership of the facilities in leasing arrangements and comparing to lease expenses being paid by the facilities, it would be impossible to determine what the impact of these rules would be on the facilities. However, given the scope of the change coupled with the fact that providers do not receive reimbursement at full cost through their per diem, the rule is expected to have a relatively minimal impact .

Jobs Impact

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

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on March 18, 2020.

The following rule-making action is adopted:

ITEM 1. Amend subrule 81.6(6) as follows:

81.6(6) *Census of ~~public assistance recipients~~ Medicaid members.* Census figures of ~~public assistance recipients~~ Medicaid members shall be obtained on the last day of the month ending the reporting period.

ITEM 2. Rescind paragraph **81.6(11)“j”** and adopt the following **new** paragraph in lieu thereof:

j. For financial and statistical reports received after [the effective date of these rules], the depreciation, as limited in this rule, may be included as an allowable patient cost.

(1) Limitation on calculation. Depreciation shall be calculated based on the tax cost using only the straight-line method of computation and recognizing the estimated useful life of the asset as defined in the most recent edition of the American Hospital Association Useful Life Guide.

(2) Limitation — full depreciation. Once an asset is fully depreciated, no further depreciation shall be claimed on that asset.

(3) Change of ownership. Depreciation is further limited by the limitations in subrule 81.6(12).

ITEM 3. Rescind paragraph **81.6(11)“m”** and adopt the following **new** paragraph in lieu thereof:

~~*m.* For financial and statistical reports received after [the effective date of these rules], the following definitions, calculations, and limitations shall be used to determine allowable rent expense on a cost report.~~

(1) Landlord's other expenses. Landlord's other expenses are limited to amortization, mortgage interest, property taxes unless claimed as a lessee expense, utilities paid by the landlord unless claimed as a lessee expense, property insurance, and building maintenance and repairs.

(2) Reasonable rate of return. Reasonable rate of return means the historical cost of the facility in the hands of the owner when the facility first entered the Medicaid program multiplied by the 30-year Treasury bond rate as reported by the Federal Reserve Board at the date of lease inception.

(3) Nonrelated party leases. When the operator of a participating facility rents from a party that is not a related party, as defined in paragraph 81.6(11) "l," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.6(11) "j" plus the landlord's other expenses, plus a reasonable rate of return; or

2. Actual rent payments.

(4) Related party leases. When the operator of a participating facility rents from a related party, as defined in paragraph 81.6(11) "l," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.6(11) "j" plus the landlord's other expenses; or

2. Actual rent payments.

ITEM 4. Amend subparagraph **81.6(16) "h" (5)** as follows:

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, ~~400 Army Post Road~~ P.O. Box 36450, Des Moines, Iowa 50315. A qualifying facility may request one or both types of additional reimbursement.

1. to 3. No change.

ITEM 5. Rescind paragraph **81.10(4) "h"** and adopt the following new paragraph in lieu thereof:

h. Ventilator patients.

(1) Definition. For purposes of this paragraph only, "ventilator patients" means Medicaid-eligible patients who, as determined by the quality improvement organization, require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care.

(2) Reimbursement. In-state nursing facilities shall receive reimbursement for care of ventilator patients equal to the sum of the Medicare-certified hospital-based nursing facility rate plus the Medicare-certified hospital-based nursing facility non-direct care rate component as defined in subparagraph 81.6(16) "f"(3). Facilities may continue to receive this reimbursement at this rate for 30 days after a ventilator patient is weaned from a ventilator if, during the 30 days, the patient continues to reside in the facility and continues to meet skilled care criteria.

ITEM 6. Amend paragraph **81.10(5)“a”** as follows:

a. Supplies or services that the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs except for customized wheelchairs for which separate payment may be made pursuant to ~~441—subparagraph 78.10(2)“a”(4), 441—paragraph 78.10(2)“d.”~~ medical supplies except for those listed in ~~441—paragraph 78.10(4)“b,”~~ oxygen except under circumstances specified in ~~441—paragraph 78.10(2)“a,”~~ and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician, ~~except for those specified in 441—paragraph 78.1(2)“f.”~~

(5) Fees charged by medical professionals for services requested by the facility that do not meet criteria for direct Medicaid payment.

ITEM 7. Amend paragraph **81.13(5)“e”** as follows:

e. *Privacy and confidentiality.* The resident has the right to personal privacy and confidentiality of personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, ~~written and telephone communications,~~ personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

~~(2) The facility must respect the resident’s right to personal privacy, including the right to privacy in the resident’s oral (that is, spoken or sign language), written, and electronic communications.~~

~~(2) (3)~~ Except as provided in subparagraph ~~(3)(4)~~ below, the resident may approve or refuse the release of personal and clinical records to any person outside the facility.

~~(3) (4)~~ The resident’s right to refuse release of personal and clinical records does not apply ~~when the resident is transferred to another health care institution or record release is required by law.~~ to the following:

- The release of personal and clinical records to a health care institution to which the resident is transferred; or
- A record release that is required by law.

ITEM 8. Rescind paragraph **81.13(5)“i”** and adopt the following **new** paragraph in lieu thereof:

i. Mail. The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident, whether delivered by a postal service or by other means, including the right to:

- (1) Privacy of such communications consistent with this section; and
- (2) Access to stationary, postage, and writing implements at the resident’s own expense.

ITEM 9. Adopt the following **new** paragraph **81.13(5)“q”**:

q. Electronic communication. The resident has the right to have reasonable access to and privacy in the resident’s use of electronic communications, including, but not limited to, email and video communications, and for Internet research:

- (1) If accessible to the facility;
- (2) At the resident’s expense, if any additional expense is incurred by the facility to provide such access to the resident; and
- (3) To the extent that such use may comply with state and federal law.

ITEM 10. Amend subparagraph **81.13(9)“b”(7)** as follows:

- (7) Automated data processing requirement.
 1. to 3. No change.
 4. The facility must transmit MDS data in the ASCH format specified by CMS.

Comments and Responses on ARC 4740C
Nursing Facility Cost Reporting
Received November 26, 2019

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

1. Jeffrey Steggerda, President, Brighton Consulting Group
2. Jhonna DeMarcky, Director – Healthcare, CliftonLarsonAllen
3. Brent Willett, President & CEO, Iowa Health Care Association
4. Kendall Watkins, Attorney, Kendall R. Watkins, P.C.

COMMENT:

The Department received 34 comments from four respondents on the proposed rules. The comments and corresponding responses from the Department are as follows:

1. Four respondents commented asking about the intent of the Iowa Medicaid Enterprise (IME) in changing the lease rule.

Department Response: The Provider Cost Audit and Rate Setting Unit (PCA) worked with IME Policy Staff and the Attorney General’s (AG) office on the intent of Nursing Facility (NF) leasing rules. It was determined that the rule should be updated to more clearly present the intent of the rule and clearly identify allowable lessor cost.

2. Two respondents commented asking if the IME can clearly identify acceptable sources for reporting Landlord Costs.

Department Response: The rule change identifies allowable landlord costs. Acceptable sources for these costs would be documentation that can be provided to support the amounts being reported. Examples include documents from external sources, such as signed lease agreements, bank statements, property tax documents, along with general ledger detail, etc.

3. Two respondents commented there are specific examples where the landlord may not maintain information on a specific property when part of a larger group of properties. The respondents asked if this is an area where the IME can add specific “Landlord Information Reporting Requirements” and include these in the Provider Manual.

Department Response: The provider/landlord would be responsible for identifying the historical cost of the assets and expenses related to the property. The Provider Manual will be updated for the rule change and will take into consideration this request.

4. Three respondents commented asking if the department can provide an initial form or schedule for each of their clients impacted by this rule change. Additionally, the respondents commented asking that since the IME has all of the historical cost information, will the IME use historical cost report information and can the form created by the IME be populated by the IME.

Department Response: The IME may not have all historical cost information dating back to when a facility entered the Medicaid program due to retention policies. Providers are responsible for supporting cost information included on the Financial and Statistical Reports. It is not expected that the IME will be creating a form for providers.

Specific to a reasonable rate of return, the calculation of a reasonable rate of return is specified in Iowa Administrative Code (IAC) 441 Chapter 81.6(11)m(2) and explains how to calculate this amount.

5. Three respondents commented asking if providers will be informed of amounts the IME has determined to be allowable, and if so, at what date will that information be given to providers.

Department Response: Providers are responsible for supporting cost information included on the Financial and Statistical Report. If information is needed during the desk review process to support reported items, PCA can request that information. If any adjustments are made to reimbursable cost, those adjustment will be sent to the provider for review, as is current procedure.

6. Two respondents commented the historical basis only references depreciable fixed assets. The respondents asked if providers can include the value of land or other assets in the amount to be used in the calculation.

Department Response: The question seems to be related to the calculation of a Reasonable Rate of Return. The rule says "...historical cost of the facility..." This can include land at its historical cost but would not include other assets.

7. Two respondents commented that in the past some landlord companies have preferred not to provide their cost information directly to their tenant. The respondents asked if there has been consideration for a separate reporting procedure for the non-related party lessors to transmit their cost information to the IME.

Department Response: Documentation to properly support all information reported on Financial and Statistical Report should be properly maintained based on IAC rules. If a lessor does not provide required information or does not support what is provided, the items of cost should not be included in reimbursable cost or can be removed from reimbursable cost by PCA.

8. Three respondents commented about the verbiage used of "tax cost" and asked what the definition of tax cost is, what the impact of using tax cost would be, and if there will be additional record keeping requirements related to using tax cost.

Department Response: The use of "tax cost" in IAC 441 Chapter 81.6(11)j was not changed in this rule change. There is no change to current usage; this is the historical cost of an asset and depreciation is to be calculated based on the straight-line basis. Therefore, there is no impact on providers and there are no additional schedules that will need to be created.

9. One respondent commented asking if there is no existing determination of the financial impact to providers, will the Department of Human Services (DHS) consider delaying the effective date until that calculation can be determined.

Department Response: There have not been discussions on delaying the rule change.

10. One respondent commented this area of reporting and the providers potentially impacted have limited access to historical information that may be necessary to comply with the changes. The analysis of the underlying information can be very complex and labor intensive. The respondent asked if the rule changes can be delayed until the specific providers impacted are identified and the potential impact can be determined.

Department Response: There have not been discussions on delaying the rule change. If a provider has been through a Change of Ownership (CHOW) and/or leases the facility where services are provided, they may be impacted.

11. One respondent commented asking if DHS can clarify how the treatment of depreciation will change following a change of ownership (CHOW).

Department Response: The treatment of depreciation following a CHOW should not change. The asset cost basis and depreciation for assets purchased by the previous owner are carried forward to the new owner. The new owner has been limited to the previous owner's cost basis in the asset (historical cost). In the case where multiple CHOWs have occurred, the original owner's basis in the asset continues to be carried forward and determines the allowable depreciation on the Financial and Statistical Report.

12. One respondent commented asking how many providers does DHS estimate could be impacted by the proposed rule changes.

Department Response: If a provider has been through a CHOW and/or leases the facility where services are provided, they may be impacted. Based on the Fiscal Year

(FY) 2018 NF Financial and Statistical Reports, there were 146 providers that had some amount of lease expense reported on Schedule C line 87 (Facility Lease), column 1 (Expenses per the General Ledger). Some of these providers may be leasing space other than the facility where services are provided.

13. One respondent commented asking if the rule changes impact both related party leases and non-related party leases.

Department Response: Both related party and non-related party leasing arrangements would be impacted.

14. One respondent commented asking what changes to the annual cost report would need to be implemented.

Department Response: It is not anticipated that any changes to the Financial and Statistical Report are necessary based solely on the rule change.

15. One respondent commented asking what changes to the Provider Manual for cost reporting would be necessary.

Department Response: The Provider Manual will be updated for the rule change.

16. One respondent commented asking if the IME will provide instructions detailing the information that would be required from the prior owner and the new owner based on these rule changes.

Department Response: Providers are responsible for being able to support all cost information that is included on the Financial and Statistical Report. Any documentation requested by PCA should support the reported items on the Financial and Statistical Report.

17. One respondent commented asking if the provisions in the rule changes will apply to all providers, including those in other cost-based programs, and not just leased facilities in the nursing facility program.

Department Response: This rule change is only for the Nursing Facility program.

18. One respondent commented his clients are concerned that the use of historical basis as a source of the calculation will not represent the full capital investment of the current property owners, especially those which have undergone physical renovation. In addition, based on the timeline of some information, access of part of the historical cost information may be unavailable to the current lease holder.

Department Response: Any depreciation on improvements or capital assets purchased by the lessor can be allowable depreciation. The cost basis of the items

purchased through a CHOW must be reported and depreciated based on the historical cost of the property in the hands of the original owner when the facility entered the Medicaid program. This does not change with this rule; however, providers should ensure capital assets that have changed hands through a CHOW are reporting depreciation in this way.

Providers are responsible for being able to support cost information that is included on the Financial and Statistical Report. If that support is not available, the item of cost should not be reported or included in reimbursable cost.

19. One respondent commented asking if the IME intends to send informational or instructional letters limited to those providers which may be impacted by the rule changes.

Department Response: The IME does not intend to send informational or instructional letters to only those providers that are impacted. If a provider has been through a CHOW and/or leases the facility where services are provided, they may be impacted. The IME does intend to send a general information letter about the rule change.

20. One respondent commented asking if the IME is proposing a method or some type of forum for the affected landlords and facility operators to work together to develop a timeline of information reporting for the calculation of provider payment rates.

Department Response: A forum for affected landlords and providers has not been discussed.



Iowa Department of Human Services
Information on Proposed Rules

Name of Program Specialist Sally Oudekerk	Telephone Number 515-256-4643	Email Address soudeke@dhs.state.ia.us
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1. Give a brief purpose and summary of the rulemaking:

The department has promulgated these rules in order to provide clarification on of the treatment of depreciation when a change of ownership occurs and leasing arrangements. The rules also serve to align with current federal regulations related to resident rights. The department is also updating the Iowa Medicaid Enterprise (IME) mailing address and making changes to language to reflect current operations of the IME.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

Iowa Code 249A.4

3. Describe who this rulemaking will positively or adversely impact.

The changes to the property costs will adversely affect facilities with lease arrangements as possibly not recognizing all costs in the lease agreement.

4. 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

5. What are the likely areas of public comment?

Providers will likely comment on these changes as they may see them as an attempt to adversely affect their per diem/reimbursement rate, as opposed to a clarification of the rule for the previously intended purpose.

6. 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 rules should not have an impact on private-sector jobs and employment opportunities in Iowa.



Administrative Rule Fiscal Impact Statement

Date: June 20, 2019

Agency: Human Services

IAC citation: 441 IAC 81.6

Agency contact: Sally Oudekerk

Summary of the rule:

The department has promulgated these rules in order to provide clarification on of the treatment of depreciation when a change of ownership occurs and leasing arrangements. The rules also serve to align with current federal regulations related to resident rights. The department is also updating the Iowa Medicaid Enterprise (IME) mailing address and making changes to language to reflect current operations of the IME.

Fill in this box if the impact meets these criteria:

- No fiscal impact to the state.
- Fiscal impact of less than \$100,000 annually or \$500,000 over 5 years.
- Fiscal impact cannot be determined.

Brief explanation:

Budget Analysts must complete this section for ALL fiscal impact statements.

Some providers could see a decrease in their per diem payment rate due to the rule update. The rule update seeks to clarify expenses from leasing arrangements that can be included in reimbursable cost and a standard way to calculate a reasonable rate of return for cost reporting. It is not changing how depreciation is calculated. The change to property costs could, however, adversely affect facilities with lease arrangements by not recognizing all costs.

Without having all of the lessor's financial data related to ownership of the facilities in leasing arrangements and comparing to lease expenses being paid by the facilities, it would not be possible to determine what an impact would be. However, given the scope of the change coupled with the fact that providers do not receive reimbursement of full cost through their per diem, the rule update is expected to have a relatively minimal impact.

Per diem rates are set based on allowable costs on the submitted cost reports, but would have no impact on the services provided to the residents.

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

	<u>Year 1 (FY 2020)</u>	<u>Year 2 (FY 2021)</u>
Revenue by each source:		
General fund	_____	_____
Federal funds	_____	_____
Other (specify):	_____	_____
TOTAL REVENUE	_____	_____
Expenditures:		
General fund	_____	_____
Federal funds	_____	_____
Other (specify):	_____	_____
TOTAL EXPENDITURES	_____	_____
NET IMPACT	_____	_____

This rule is required by state law or federal mandate.

Please identify the state or federal law:

Identify provided change fiscal persons:

Funding has been provided for the rule change.

Please identify the amount provided and the funding source:

Funding has not been provided for the rule.
Please explain how the agency will pay for the rule change:
The impact is expected to be minimal.

Fiscal impact to persons affected by the rule:

The change to property costs could adversely affect facilities with lease arrangements by not recognizing all costs, but the aggregate impact is expected to be minimal.

Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):

No fiscal impact.

Agency representative preparing estimate: Jason Buls

Telephone number: 515-281-5764

HUMAN SERVICES DEPARTMENT [441]

Adopted and Filed

The Human Services Department hereby amends Chapter 95, "Collections," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code chapter 252B.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 252B.4.

Purpose and Summary

This rule making aligns the Department's rules about child support recovery with recent legislative changes. 2019 Iowa Acts, Senate File 605, amended Iowa Code chapter 252B to eliminate the customer-paid application fee.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on November 20, 2019, as **ARC 4764C**.

No public comments were received.

No changes from the Notice have been made.

Adoption of Rule Making

This rule making was adopted by the Council on January 8, 2020.

Fiscal Impact

These changes are expected to generate a net revenue increase to the Child Support appropriation with a state share impact of less than \$100,000 per year.

Jobs Impact

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

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the 20-028 CSRU Fees for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date This rule making will become effective on March 18, 2020.

The following rule-making action is adopted:

ITEM 1. Amend subrule 95.2(4) as follows:

95.2(4) Application for services.

~~a.~~ A person who is not on public assistance requesting services under this chapter, except for those persons eligible to receive support services under paragraphs 95.2(2) "a," "b," and "c," shall complete and return Form 470-0188, Application for Nonassistance Support Services, for each parent from whom the person is seeking support.

(1) a. The application shall be returned to the child support recovery unit serving the county where the person resides. If the person does not live in the state, the application form shall be returned to the county in which the support order is entered or in which the other parent or putative father resides.

(2) b. The person requesting services has the option to seek support from one or both of the child's parents.

~~b.~~ An individual who is required to complete Form 470-0188, Application for Nonassistance Support Services, shall be charged an application fee in the amount set by statute. The unit shall charge one application fee for each parent from whom support is sought. The unit shall charge the fee at the time of initial application and any subsequent application for services. The individual shall pay the application fee to the local child support recovery unit before services are provided.

ITEM 2. Amend subrule 95.18(3) as follows:

95.18(3) Reapplication for services. A person whose services were denied or terminated may reapply for services under this chapter by completing the application process and paying the application fee described in subrule 95.2(4).



Iowa Department of Human Services
Information on Proposed Rules

Name of Program Specialist Kate Bigg	Telephone Number 515-281-4289	Email Address kbigg@dhs.state.ia.us
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1. Give a brief purpose and summary of the rulemaking:
This rulemaking eliminates references to the application fee paid by non-assistance customers when requesting child support services from the Child Support Recovery Unit (CSRU). Recent legislative changes to Iowa Code Chapter 252B eliminated the customer-paid application fee.
2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):
Senate File 605 (2019), which amended Iowa Code section 252B.4 to eliminate the customer-paid application fee.
3. Describe who this rulemaking will positively or adversely impact.
This rulemaking aligns current rules with recent legislative changes to Iowa Code Chapter 252B. These changes will positively impact non-assistance customers because they will no longer be required to pay an application fee when requesting child support services from CRSU.
4. Does this rule contain a waiver provision? If not, why?
No. Iowa Administrative Code Chapter 441—95 does not currently contain waiver provisions.
5. What are the likely areas of public comment?
The department does not anticipate public comment on the proposed amendments because these changes conform the rules with statutory changes to Iowa Code Chapter 252B passed by the Iowa Legislature during the 2019 Legislative Session.
6. 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.)
No.

Estimated Impact to the State by Fiscal Year

	Year 1 (FY 2020)	Year 2 (FY 2021)
Revenue by each source:		
General fund	_____	_____
Federal funds	_____	_____
Other (specify):	_____	_____
TOTAL REVENUE	_____	_____
Expenditures:		
General fund	_____	_____
Federal funds	_____	_____
Other (specify):	_____	_____
TOTAL EXPENDITURES	_____	_____
NET IMPACT	_____	_____
<p><input checked="" type="checkbox"/> This rule is required by state law or federal mandate. <i>Please identify the state or federal law:</i> Identify provided change fiscal persons: Senate File 605 (2019)</p> <p><input checked="" type="checkbox"/> Funding has been provided for the rule change. <i>Please identify the amount provided and the funding source:</i> The loss of the application fee will be offset by an increase in the annual fee for nonassistance child support cases.</p> <p><input type="checkbox"/> Funding has not been provided for the rule. <i>Please explain how the agency will pay for the rule change:</i></p>		
<p><i>Fiscal impact to persons affected by the rule:</i> These changes will positively impact non-assistance customers because they will no longer be required to pay an application fee when requesting child support services from CRSU.</p>		
<p><i>Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):</i> None anticipated.</p>		
Agency representative preparing estimate:	Diane Barrett	JH 7-15-19 [Signature]
Telephone number:	515-281-6024	