

**HUMAN SERVICES DEPARTMENT[441]**

**Notice of Intended Action**

**Proposing rule making related to consumer choices option and providing an opportunity for public comment**

The Human Services Department hereby proposes to amend Chapter 78, “Amount, Duration and Scope of Medical and Remedial Services,” and Chapter 79, “Other Policies Relating to Providers of Medical and Remedial Care,” Iowa Administrative Code.

*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*

The proposed amendments make several changes to the Consumer Choices Option (CCO) program available within the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, and physical disability waivers. The amendments consolidate the CCO service description rules into one subrule, 78.34(13). The amendments change the monthly budget billing methodology for the Financial Management Services (FMS) provider from a prepay method to a postpay method. The amendments clarify who may self-direct services. The amendments also clarify the budget and employer authority responsibilities and define how the monthly CCO budget may be used by a member self-directing services. The amendments make technical changes to remove the references to the Department service workers who are no longer involved in the CCO program. Finally, the amendments add new member and employee responsibilities to ensure proper

payments for CCO services are made.

*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).

*Public Comment*

Any interested person may submit written comments concerning this proposed rule making. Written comments in response to this rule making must be received by the Department no later than 4:30 p.m. on March 5, 2019. Comments should be directed to:

Harry Rossander

Bureau of Policy Coordination

Department of Human Services

Hoover State Office Building, Fifth Floor

1305 East Walnut Street

Des Moines, Iowa 50319-0114

Email: [policyanalysis@dhs.state.ia.us](mailto:policyanalysis@dhs.state.ia.us)

### *Public Hearing*

No public hearing is scheduled at this time. As provided in Iowa Code section 17A.4(1)“b,” an oral presentation regarding this rule making may be demanded by 25 interested persons, a governmental subdivision, the Administrative Rules Review Committee, an agency, or an association having 25 or more members.

### *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 proposed:

ITEM 1. Amend subrule 78.34(13) as follows:

**78.34(13) *Consumer choices option.*** The consumer choices option provides a member with a flexible monthly individual budget that is based on the member’s service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member’s assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member’s assessed need or goal established in the member’s service plan. The consumer choices option is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13)“g” and employer authority tasks

identified in paragraph 78.34(13)“h,” or who delegates the budget or employer authority tasks identified in paragraph 78.34(13)“i.” Components of this service are set forth below.

a. No change.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member’s service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) No change.

~~(2) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13)“b”(1) based on actual unit costs from the previous fiscal year plus a cost of living adjustment.~~ Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

~~(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall~~

~~apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.~~ Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

~~(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.~~ Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

~~(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)“b”(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)“b”(3). Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:~~

- ~~1. Consumer-directed attendant care (unskilled).~~
- ~~2. Home and vehicle modification.~~
- ~~3. Prevocational services.~~
- ~~4. Basic individual respite care.~~
- ~~5. Specialized medical equipment.~~
- ~~6. Supported community living.~~
- ~~7. Supported employment.~~
- ~~8. Transportation.~~

~~(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13)“b”(2) or the utilization adjustment factor in subparagraph 78.34(13)“b”(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member’s service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment. Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:~~

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

~~(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.~~

(7) The department shall determine an average unit cost for each service listed in subparagraphs 78.34(13)“b”(1) to (6) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(8) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member’s service plan before calculating the value of that service to be included in the individual budget amount.

(9) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent.

(10) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)“b”(7). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)“b”(8).

(11) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph

78.34(13) “b”(7) or the utilization adjustment factor in subparagraph 78.34(13) “b”(8). The anticipated costs may include the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by the Iowa Medicaid Enterprise or managed care organization as the least costly option to meet the member’s need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member’s service plan and authorized by the case manager or community-based case manager.

(12) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. No change.

d. *Optional service components.* A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services ~~or goods~~ that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by

the member's case manager or ~~service worker~~ community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or ~~service worker~~ community-based case manager.

(3) No change.

*e. Development of the individual budget.* The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) and (2) No change.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)“*d.*”At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services may exceed the amount of service or supports authorized in the member's service plan. Costs of the following items and services shall not be covered by the individual budget:

1. to 22. No change.

23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member's service plan.

24. Residential services provided to three or more members living in the same residential setting.

(4) The costs of any approved home or vehicle modification , assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification , an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications , assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or ~~service worker~~ community-based case manager. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment, as identified in subparagraph 78.34(13) "b"(11).

(5) No change.

*f. Savings plan.* A member savings plan must be in writing and be approved before the start of the savings plan by the department ~~before the start of the savings plan~~ for fee-for-service members or by the member's managed care organization for members in managed care. ~~Amounts~~ Budget amounts allocated to the savings plan must result from efficiencies in meeting ~~identified~~ the member's service needs ~~of the member~~ identified in the member's service plan.

(1) The savings plan shall identify:

1. to 4. No change.

5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. ~~The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month.~~ Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

~~(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies.~~ Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. and 2. No change.

3. Be approved by the member's case manager ~~or service worker~~ or

community-based case manager.

(4) All funds allocated to a savings plan ~~that are not expended by December 31 of each year shall revert to the Medicaid program~~ to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(5) No change.

*g. Budget authority.* The member shall have authority over the individual budget authorized by the department or managed care organization to perform the following tasks:

(1) No change.

(2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). ~~The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.~~

(3) Schedule the provision of services. ~~Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative member's employee is unable to provide~~

services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13) "i."

(5) No change.

~~*h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.~~

~~(1) The representative must be at least 18 years old.~~

~~(2) The representative shall not be a current provider of service to the member.~~

~~(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.~~

~~(4) The representative shall not be paid for this service.~~

*h. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

- (1) Recruit and hire employees.
- (2) Verify employee qualifications.
- (3) Specify additional employee qualifications.
- (4) Determine employee duties.
- (5) Determine employee wages and benefits.
- (6) Schedule employees.
- (7) Train and supervise employees.

~~*i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common law employer has the right to direct and control the performance of the services. The member may perform the following functions:~~

- ~~(1) Recruit employees.~~
- ~~(2) Select employees from a worker registry.~~
- ~~(3) Verify employee qualifications.~~
- ~~(4) Specify additional employee qualifications.~~
- ~~(5) Determine employee duties.~~
- ~~(6) Determine employee wages and benefits.~~
- ~~(7) Schedule employees.~~
- ~~(8) Train and supervise employees.~~

*i. Delegation of budget and employer authority.* The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who

do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13)“g” and employer authority tasks identified in paragraph 78.34(13)“h.” Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member’s service plan.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.

(4) The representative shall not be paid for this service.

*j.* No change.

*k. Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member’s representative:

(1) Assist the member with developing the member’s initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.

(3) to (11) No change.

*l. Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

(1) and (2) No change.

(3) ~~Enter~~ Monitor and track the approved individual budget into the web-based tracking system chosen by the department amount authorized each month and enter document all expenditures as they are paid.

(4) to (17) No change.

(18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

*m. Responsibilities of the member and the employee.* A member participating in the CCO and the member's employee(s) are responsible for the following:

(1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.

(2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.

(3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act and is not eligible to receive federal funds.

(4) Employees shall complete, sign and date Form 470-4429, Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. Documentation shall comport with 441—subparagraph 79.3(2)“c”(3), “Service documentation.”

(5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13)“m”(5) prior to the timecard’s submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

ITEM 2. Rescind subrule 78.37(16) and adopt the following **new** subrule in lieu thereof:

**78.37(16)** *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

ITEM 3. Rescind subrule 78.38(9) and adopt the following **new** subrule in lieu thereof:

**78.38(9)** *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

ITEM 4. Rescind subrule 78.41(15) and adopt the following **new** subrule in lieu thereof:

**78.41(15)** *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

ITEM 5. Rescind subrule 78.43(15) and adopt the following **new** subrule in lieu thereof:

**78.43(15) Consumer choices option.** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

ITEM 6. Rescind subrule 78.46(6) and adopt the following **new** subrule in lieu thereof:

**78.46(6) Consumer choices option.** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

ITEM 7. Amend subrule 79.1(2), provider category “HCBS waiver service providers,” paragraphs “32,” “33,” and “34,” as follows:

**79.1(2) Basis of reimbursement of specific provider categories.**

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
32. Self-directed personal care	Rate negotiated by member	Determined by member’s individual budget.  When an individual who serves as a member’s legal representative provides services to the member as allowed by 79.9(7) “b,” the payment rate must be

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
33. Self-directed community supports and employment	Rate negotiated by member	<del>based on the skill level of            the legal representative and            may not exceed the median            statewide reimbursement            rate for the service unless            the higher rate receives            prior approval from the            department</del> <u>441—subparagraph            78.34(13)“g”(2).</u>
		Determined by member’s individual budget. When an individual who serves as a member’s legal representative provides services to the member as allowed by 79.9(7)“b,” the payment rate must be <del>based on the skill level of            the legal representative and</del>

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
34. Individual-directed goods and services	Rate negotiated by member	<p><del>may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department</del></p> <p><u>441—subparagraph 78.34(13) “g”(2).</u></p> <p>Determined by member’s individual budget. When an individual who serves as a member’s legal representative provides services to the member as allowed by 79.9(7) “b,” the payment rate must be based on <del>the skill level of the legal representative and</del> <del>may not exceed the median statewide reimbursement</del></p>

Provider category

Basis of  
reimbursement

Upper limit

~~rate for the service unless  
the higher rate receives  
prior approval from the  
department~~

441—subparagraph

78.34(13)“g”(2).

ITEM 8. Rescind and reserve subrule **79.1(9)**.



Iowa Department of Human Services  
**Information on Proposed Rules**

Name of Program Specialist Brian Wines	Telephone Number 515.256.4661	Email Address bwines@dhs.state.ia.us
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1. Give a brief summary of the rule changes:

The proposed rules will make several changes to the Consumer Choices Option program available in the AIDS/HIV, Brain Injury, Elderly, Health and Disability, Intellectual Disability, and Physical Disability Waivers. The rule changes consolidate the CCO service description rules into one chapter (441-78.34(13)) and all other waivers programs reference the CCO rules in 441-78.34(13). The proposed rules will change the monthly budget billing methodology for the Financial Management Services (FMS) provider from a prepay method to a post pay method. The rules clarify who may self-direct services. The rules also clarify the budget and employer authority responsibilities and define how the monthly CCO budget may be used by a member self-directing services. The rules make some technical changes to remove the reference to the DHS service worker who no longer are involved in the CCO program. And finally, the rules add new member and employee responsibilities to assure proper payment for CCO services are made.

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

249A.4

3. What is the reason for the Department requesting these changes?

The Department is requesting the rule changes for increased efficiency of billing CCO services provided to the fee-for-service waiver population and consistency in FMS billing processes that are similar to the managed care organizations. The rules also clarify CCO service descriptions for consistent implementation for all CCO program users.

4. What will be the effect of this rule making (who, what, when, how)?

The effect of these rules will be simplified billing for CCO services by the FMS through changes made to the FMS billing process.

5. Is the change mandated by State or Federal Law?

No.

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

The FMS provider will be required to make systemic changes in their billing process. This change will allow for efficiencies in billing and reduction in work required to implement CCO. The change will require less staff worktime for the department in managing the CCO program.

7. What are the potential benefits of this rule?

Efficiency for the FMS and the Department in the billing process for the fee-for-service population accessing CCO. The rules will bring consistency in how the Department and the MCOs pay the FMS provider for provision of CCO services.

8. What are the potential costs, to the regulated community or the state of Iowa as a whole, of this rule?

The changes to the CCO services should be cost neutral.

9. Do any other agencies regulate in this area? If so, what agencies and what Administrative Code sections apply?

N/A

10. What alternatives to direct regulation in this area are available to the agency? Why were other alternatives not used?

The identified changes to the CCO program require rules to be promulgated.

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

No, Medicaid has determined that the rules should be applicable to all members and providers. Members and providers can request waivers pursuant to the Department's general rule on waivers or exceptions to policy, at Iowa Administrative Code r. 441-1.8.

12. What are the likely areas of public comment?

The department may receive public comment for members and their employees on the higher level of responsibilities around the provision and documentation of CCO services.

13. 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 will not have an impact on private-sector jobs or employment opportunities in Iowa.



## Administrative Rule Fiscal Impact Statement

Date: 8/22/2018

**Agency:** Human Services

**IAC citation:** 441 IAC

**Agency contact:** Brian Wines

**Summary of the rule:**

The proposed rules will make several changes to the Consumer Choices Option program available in the AIDS/HIV, Brain Injury, Elderly, Health and Disability, Intellectual Disability, and Physical Disability Waivers. The rule changes consolidate the CCO service description, change the monthly budget billing methodology from a prepay to a post pay method, and clarify who may self-direct services and the budget and employer authority responsibilities. The rules also make some technical changes and add new member and employee responsibilities to assure proper payment for CCO services are made.

The Department is requesting the rule changes for increased efficiency of billing CCO services provided to the fee-for-service waiver population and consistency in FMS billing processes that are similar to the managed care organizations. The rules also clarify CCO service descriptions for consistent implementation for all CCO program users.

*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:**

The rule changes will create efficiency for the FMS and the Department in the billing process for the fee-for-service population accessing CCO. The rules will bring consistency in how the Department and the MCOs pay the FMS provider for provision of CCO services. The changes to the CCO services are expected to be cost neutral.

*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 (SFY19)</u>	<u>Year 2 (SFY20)</u>
<b>Revenue by each source:</b>		
General fund	_____	_____
Federal funds	_____	_____
Other (specify):	_____	_____
<b>TOTAL REVENUE</b>	_____	_____
<b>Expenditures:</b>		
General fund	_____	_____
Federal funds	_____	_____
Other (specify):	_____	_____
<b>TOTAL EXPENDITURES</b>	_____	_____
<b>NET IMPACT</b>	<u>No Impact</u>	<u>No Impact</u>

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

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

Funding has not been provided for the rule.  
*Please explain how the agency will pay for the rule change:*  
 There are no expected costs resulting from the changes.

***Fiscal impact to persons affected by the rule:***

The FMS provider will be required to make systemic changes in their billing process. This change will allow for efficiencies in billing and reduction in work required to implement CCO.

***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