HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," 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.

These amendments implement the provider qualifications, scope of services and reimbursement methodology for community-based neurobehavioral rehabilitation residential and intermittent services.

The Department entered into an agreement with Community NeuroRehab in 2010 to provide community-based neurobehavioral rehabilitation services for adults who have experienced a brain injury co-occurring with a mental health diagnosis, as an alternative to costly out-of-state facility-based neurobehavioral rehabilitation, hospitalization, institutionalization, incarceration or homelessness. The Department has been funding these services through exception to policy while administrative rules were being developed with a stakeholder group representing brain injury professionals. These services yield a cost savings to the state for members who would otherwise have been admitted to out-of-state facility-based services for neurobehavioral rehabilitation.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 2113C** on August 19, 2015.

The Department received comments from two respondents during the public comment period. A summary of the comments and the Department's responses are as follows:

COMMENT 1: Both respondents, stated that the Department should add "formal fire prevention and reaction training on a regular basis" to paragraph 77.52(3)"c".

DEPARTMENT RESPONSE 1: The Department agreed with the comment and will amend paragraph 77.52(3)"c" as follows:

c. Within 30 days of commencement of direct service provision employees shall complete Cardio Pulmonary Resuscitation (CPR) Training, a First Aid course, Fire Prevention and Reaction Training and Universal Precautions Training. These training courses shall be completed no less than annually.

COMMENT 2: The respondent stated that the Department should add that the member should participate in the evaluation of their progress towards treatment goals to subparagraph 77.52(3)"k"(3). The reference to the evaluation of progress towards treatment goals is implied in the section above regarding development of the individualized service plan (ISP) but appears to have been omitted in this section. The reference to the evaluation of progress towards treatment goals must be here to assure person-centered focus.

DEPARTMENT RESPONSE 2: The Department agreed with the comment and will amend subparagraph 77.52(3)"k"(3) as follows:

(3) The member and their treatment team evaluate the members' progress towards treatment goals ~~is evaluated~~ regularly and no less than quarterly. Treatment plans are

reviewed regularly and are revised as the member's status or needs change to reflect the member's progress and response to treatment, but no less than quarterly

COMMENT 3: The respondent stated that any restraint, particularly one of a chemical nature, must be in accordance with a prescription, regular oversight, and support of a licensed medical professional in subparagraph 77.52(3)"k"(5). Overall the language about the use of retreating is outdated and not in accordance with best practice of positive behavioral supports. The language should be brought into accordance with best practice in this area.

DEPARTMENT RESPONSE 3: The homes where the residential community-based neurobehavioral rehabilitation services are provided are licensed as Residential Care Facilities with specialized license for three- to five-beds under Iowa Administrative Code 481--63.47. These administrative rules address resident's rights and the use of least restrictive interventions. The Department agreed with the comment and will amend subparagraph 77.52(3)"k"(5) as follows:

(5) <u>When a member requires any restrictive interventions the interventions will be implemented in accordance with Iowa Administrative Code, subrule 481—63.23(4), rule 481—63.33, and rule 481—63.37.</u> When a member has a guardian or legal representative that person will provide informed consent to treat and provide informed consent for any restrictive interventions that may be required to protect the health or safety of the member. Restrictive interventions include but are not limited to:

COMMENT 4: Both respondents stated that there is an error in the sentence found in subparagraph 78.56(2)"b"(2). "OTHER THAN" should read instead as "INCLUSIVE OF".

DEPARTMENT RESPONSE 4: The Department agreed with the comment from the respondent. Subparagraph 78.56(2)"b"(2) will be amended as follows:

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care ~~other than hospitalization, institutionalization, incarceration or homelessness. treatment~~ more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or in-patient hospitalization)

COMMENT 5: The respondent stated that subparagraph 77.52(3)"a"(6) does not specify how competency in performing assigned duties and interacting with members will be assessed.

DEPARTMENT RESPONSE 5: Providers have expressed that it is the providers that are best qualified to determine which methodologies are most useful in assessing the competency of the direct care personnel. The Department does not prescribe specific methodologies of personnel competency assessment for other Medicaid services and will continue to expect that the providers will determine the best methods of assessing the competency of their direct care personnel that is most appropriate for their individual organizations. The Department will not amend the proposed rulemaking in response to this comment.

COMMENT 6: The respondent commented that the mention of chemical restraint as a restrictive intervention which may be required does not specify how or by whom such a restraint may be prescribed, and implies that it is something imposed by the program in subparagraph 77.52(3)"k"(5). In addition, no parameters are noted for the use of any restraints and no staff training is required relative to the implementation of manual

or mechanical restraints. Further, no mention is made of what type of professional must approve such a plan and how it is to be monitored. Rules governing more institutional levels of care (SNF, ICF, RCF) require that measures used must be the "least restrictive", surely any restraint measures used in a community-based setting should include this language and include strict controls as to their use, if allowed at all.

DEPARTMENT RESPONSE 6: The Department agreed with the respondent and believes that the proposed changes to the amendments found in Department Response 3 above addresse this comment.

COMMENT 7: The subparagraphs 78.56(2)"b"(1) and (2) note that "the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless; or is at risk of hospitalization, institutionalization, incarceration or homelessness" or has a history of such. This language does not specify that such treatment has occurred after the individual has sustained a brain injury, so individuals may qualify for this level of service by virtue of their behavior/symptomology unrelated to a brain injury; consequently, many individuals will qualify for this level or service by their premorbid history which we do not believe was the intent of the legislature, Iowa Medicaid Enterprise (IME), or the provider work group focused on the development of these rules.

DEPARTMENT RESPONSE 7: The Department stated that in order to be eligible for Community-based Neurobehavioral Rehabilitation Services (CNRS) services, the member must have brain injury diagnosis as set forth in rule 441--83.81. For the purposes of clarity paragraph 78.56(2)"b" will be amended as follows:

b. Risk factors. The member has the following <u>post brain injury</u> risk factors:

The Council on Human Services adopted these amendments on October 14, 2015.

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

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

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

These amendments will become effective December 16, 2015.

The following amendments are adopted.

ITEM 1. Adopt the following **new** rule 441—77.52(249A):

441—77.52(249A) Community-based neurobehavioral rehabilitation services.

77.52(1) Definitions.

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Brain injury" means a diagnosis in accordance with rule 441—83.81(249A).

"Health care" means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

"Intermittent community-based neurobehavioral rehabilitation services" means services provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

"Member" means a person who has been determined to be eligible for Medicaid

under 441—Chapter 75.

"Neurobehavioral rehabilitation" refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

"Standardized assessment" means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's needs.

77.52(2) Eligible providers. The following agencies may provide community-based neurobehavioral rehabilitation residential and intermittent services:

a. An organization that is accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider.

b. Agencies not accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider that have applied for accreditation within the last 16 months to provide services may be

enrolled. However, an organization that has not received accreditation within 16 months after application shall no longer be a qualified provider.

77.52(3) Provider standards. All community-based neurobehavioral rehabilitation service providers shall meet the following criteria:

a. The organization meets the outcome-based standards for community-based neurobehavioral rehabilitation service providers as follows:

(1) The organization shall provide high-quality supports and services to members.

(2) The organization shall have a defined mission commensurate with members' needs, desires, and abilities.

(3) The organization shall be fiscally sound and shall establish and maintain fiscal accountability.

(4) The program administrator shall be a certified brain injury specialist trainer (CBIST) through the Academy of Certified Brain Injury Specialists or a certified brain injury specialist under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441—83.81(249A) with additional certification as approved by the department.

(5) A minimum of 75 percent of the organization's administrative and direct care personnel shall meet one of the following criteria:

1. Have a bachelor's degree in a human services-related field;

2. Have an associate's degree in human services with two years of experience working with individuals with brain injury;

3. Be an individual who is in the process of seeking a degree in the human services field with two years of experience working with individuals with brain injury; or

4. Be a certified brain injury specialist or have other brain injury certification as approved by the department.

(6) The organization shall have qualified personnel trained in the provision of direct care services to people with a brain injury. The training must be commensurate with the needs of the members served. Employees shall receive training and demonstrate competency in performing assigned duties and in all interactions with members, including but not limited to:

1. Promotion of a program structure and support for persons served so they can re-learn or regain skills for community inclusion and access.

2. Compensatory strategies to assist in managing ADLS (activities of daily living).

3. Quality of life issues.

4. Behavioral supports and identification of antecedent triggers.

5. Health and medication management.

6. Dietary and nutritional programming.

7. Assistance with identifying and utilizing assistive technology.

8. Substance abuse and addiction issues.

9. Self-management and self-interaction skills.

10. Flexibility in programming to meet members' individual needs.

11. Teaching adaptive and compensatory strategies to address cognitive, behavioral, physical, psychosocial and medical needs.

12. Community accessibility and safety.

13. Household maintenance.

14. Service support to the member's family or support system related to the member's neurobehavioral care.

b. The organization provides training and supports to its personnel. Training shall be provided before direct service provision and must be ongoing. At a minimum the training includes the following:

(1) Completion of the department-approved brain injury training modules.

(2) Member rights.

(3) Confidentiality and privacy.

(4) Dependent adult and child abuse prevention and mandatory reporter training.

(5) Individualized rehabilitation treatment plans.

(6) Major mental health disorder basics.

c. Within 30 days of commencement of direct service provision, employees shall complete cardiopulmonary resuscitation (CPR) training, a first aid course, Fire Prevention and Reaction Training and universal precautions training. These training courses shall be completed no less than annually.

d. Within the first six months of commencement of direct service provision, employees shall complete training required by 441—subparagraph 78.54(3)"a"(6).

e. Within 12 months of the commencement of direct service provision, employees shall complete a department-approved, nationally recognized certified brain injury specialist training.

f. The organization shall have in place an outcome management system which measures the efficiency and effectiveness of service provision, including members' preadmission location of service, length of stay, discharge location, reason for discharge,

member and stakeholder satisfaction, and access to services.

g. The organization shall have in place a systematic, organization-wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization shall be required to:

(1) Measure and analyze organizational activities and services quarterly.

(2) Conduct satisfaction surveys with members, family members, employees and stakeholders, and share the information with the public.

(3) Conduct an internal review of member service records at regular intervals.

(4) Track major and minor incident data according to subrule 77.37(8) and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof; and analyze the data to identify trends annually to ensure the health and safety of members served by the organization.

(5) Continuously identify areas in need of improvement.

(6) Develop a plan to address the identified areas in need of improvement.

(7) Implement the plan, document the results, and report to the governing body annually.

h. The organization shall have in place written policies and procedures and a personnel training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The organization's governing body shall have an active role in the administration of the organization.

j. The organization's governing body shall receive and use input from local community stakeholders, members participating in services, and employees and shall

provide oversight that ensures the provision of high-quality supports and services to members.

k. The organization shall implement the following outcome-based standards for rights and dignity:

(1) Members are valued.

(2) The member and the member's treatment team mutually develop an individualized service plan (ISP) that takes into account the member's individual strengths, barriers and interests. The service plan shall include goals which are based on the member's need for services and shall address the neurobehavioral challenges and environmental needs as identified in the member's individual standardized comprehensive functional neurobehavioral assessment.

(3) The member and their treatment team evaluate the member's progress towards treatment goals regularly and no less than quarterly. Treatment plans are reviewed regularly, but not less than quarterly, and are revised as the member's status or needs change to reflect the member's progress and response to treatment.

(4) The member and the member's legal representative have the right to file grievances regarding the provider's implementation of the organizational standards, or its employee's or contractual person's action which affects the member. The provider shall provide to members the policies and procedures for member grievances and appeals at the commencement of services and annually thereafter.

(5) When a member requires any restrictive interventions the interventions will be implemented in accordance with Iowa Administrative Code, subrule 481—63.23(4), rule 481—63.33, and rule 481—63.37. When a member has a guardian or legal

representative, the guardian or legal representative shall provide informed consent to treat and consent for any restrictive interventions that may be required to protect the health or safety of the member. Restrictive interventions include but are not limited to:

1. Restraint, including chemical restraint, manual restraint or mechanical restraint;

2. Alarms added to a member's natural environment including doors, windows, refrigerators, cabinets, and other home appliances and fixtures;

3. Exclusionary time out;

4. Intensive staffing for control of behavior;

5. Limited access or contingency access to preferred items or activities naturally available in the member's environment;

6. Reprimand;

7. Response cost; and

8. Use of psychotropic medications to control the occurrence of an unwanted behavior.

(6) Members receive individualized services.

(7) Members or their legal representatives provide written consent regarding which personal information is shared and with whom.

(8) Members receive assistance with accessing financial management services as needed.

(9) Members receive assistance with obtaining preventive, appropriate and timely medical and dental care.

(10) The member's living environment is reasonably safe and located in the

community.

(11) The member's desire for intimacy is respected and supported.

ITEM 2. Adopt the following **new** rule 441—78.56(249A):

441—78.56(249A) Community-based neurobehavioral rehabilitation services. Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

78.56(1) Definitions.

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Brain injury" means a diagnosis in accordance with rule 441—83.81(249A).

"Health care" means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

"Intermittent community-based neurobehavioral rehabilitation services" are provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in their own home and community.

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

"Neurobehavioral rehabilitation" refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury.

Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

"Standardized assessment" means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's individual needs.

78.56(2) Member eligibility. To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. Brain injury diagnosis. To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

b. Risk factors. The member has the following post brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more

intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or in-patient hospitalization).

c. Need for assistance. The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

d. Needs assessment. The member shall have a standardized comprehensive functional neurobehavioral assessment reviewed or completed by a licensed neuropsychologist, neurologist, M.D., or D.O. The neurobehavioral assessment shall document the member's need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. Standards for assessment. Each member will have had a department-approved, standardized comprehensive functional neurobehavioral assessment completed within the 90 days prior to admission. Each needs assessment will include the assessment of a member's individual physical, emotional, cognitive, medical and psychosocial residuals related to the member's brain injury, which must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member's ability to self-manage the member's symptoms.

(3) The member's rehabilitation and medical care history to include medication

history and status.

(4) The member's employment history and the member's barriers to employment.

(5) The member's dietary and nutritional needs.

(6) The member's community accessibility and safety.

(7) The member's access to transportation.

(8) The member's history of substance abuse.

(9) The member's vulnerability to exploitation and history of risk of exploitation.

(10) The member's history and status of relationships, natural supports and socialization.

f. Emergency admission. In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

78.56(3) Covered services.

a. Service setting.

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections and appeals; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member's own residence in the community.

(3) No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an intermediate care facility for persons with intellectual disabilities, nursing facility or skilled nursing facility.

b. Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:

(1) Prescriptive programming to maintain and advance progress made in rehabilitation;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Assistance in obtaining preventative, appropriate and timely medical and dental care;

(4) Compensatory strategies to assist in managing ADLS (activities of daily living);

(5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;

(6) Behavioral and cognitive programming and supports;

(7) Medication management and consultation with pharmacy;

(8) Health and wellness management including dietary and nutritional programming;

(9) Progressive physical strengthening, fitness and retraining;

(10) Assistance with obtaining and use of assistive technology;

(11) Sobriety support development;

(12) Assistance with the self-identification of antecedent triggers;

(13) Assistance with preparation for transition to less intensive services including accessing the community;

(14) Flexibility in programming to meet individual needs;

(15) Assistance with re-learning coping and compensatory strategies;

(16) Support and assistance in seeking substance abuse and co-occurring

disorders services;

(17) Support and assistance with obtaining legal consultation and services;

(18) Assistance with community accessibility and safety;

(19) Assistance with re-learning household maintenance;

(20) Assistance with recreational and leisure skill development;

(21) Assistance with the development and application of self-advocacy skills to navigate the service system;

(22) Opportunities to learn about brain injury and individual needs following brain injury;

(23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(24) Assistance with pursuit of education and employment goals;

(25) Protective oversight in the residential setting and community;

(26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;

(27) Transitional support and training;

(28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;

(29) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum independence, community access, and integration.

c. Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of

the member and may include:

(1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Compensatory strategies to assist in managing ADLS (activities of daily living);

(4) Behavioral supports;

(5) Assistance with obtaining and use of assistive technology;

(6) Assistance with the self-identification of antecedent triggers;

(7) Flexibility in programming to meet the member's individual needs;

(8) Assistance with re-learning coping and compensatory strategies;

(9) Assistance with the development and application of self-advocacy skills to navigate the service system;

(10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;

(12) Transitional support and training;

(13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.

d. Approval of treatment plan. The community-based neurobehavioral services

provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

e. Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to the IME medical services unit.

(1) The IME medical services unit will approve the provider's treatment plan if:

1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);

2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;

3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

4. The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and

5. The treatment plan does not exceed 180 days in duration.

(2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.

f. Subsequent plans. The IME medical services unit may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.56(4) and to the conditions pursuant to subrule 78.56(3).

g. Quality review. The IME medical services unit may perform the quality review to evaluate:

(1) The time elapsed from referral to rehabilitation treatment plan development;

(2) The continuity of treatment;

(3) The length of stay per member;

(4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;

(5) Gaps in service;

(6) The results achieved;

(7) Member and stakeholder satisfaction;

(8) The provider's compliance with standards listed in rule 441—77.54(249A).

78.56(4) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. Is the least costly type of service that can reasonably meet the medical needs of the member; and

d. Is in accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding best practices in the field.

78.56(5) Documentation standards. Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

ITEM 3. Adopt the following **new** provider category in subrule **79.1(2)** as follows:

Provider category	Basis of reimbursement	Upper limit
Community-based neurobehavioral rehabilitation services	Fee schedule, see 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent $21.11 per 15-minute unit.

ITEM 4. Adopt the following **new** subrule 79.1(28):

79.1(28) Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.

a. New providers. Providers who are newly enrolled shall be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

b. Established providers. After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate shall be

the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

ITEM 5. Adopt the following **new** subparagraph **79.3(2)"d"(42)**:

(42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.

1. Department-approved standardized neurobehavioral assessment tool;
2. Community-based neurobehavioral treatment order;
3. Treatment plan;
4. Clinical records documenting diagnosis and treatment history;
5. Progress or status notes;
6. Service notes or narratives;
7. Procedure, laboratory, or test orders and results;
8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable;
9. Medication administration records.

Iowa Department of Human Services

Information on Proposed Rules

Name of Program Specialist	Telephone Number	Email Address
LeAnn Moskowitz	515-256-4653	lmoskow@dhs.state.ia.us

1. Give a brief summary of the rule changes:

   These are new rules, and implement the provider qualifications, service scope and reimbursement methodology for community based neurobehavioral rehabilitation residential and intermittent services.

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

   IA Code 249AThis intensive rehabilitation service falls under the federal definition of Rehabilitative Services as defined in 42 CFR 400.130 (d).

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

   The department entered into an agreement with Community NeuroRehab in 2010 to provide community based neurobehavioral rehabilitation services for adults who have experienced a brain injury co-occurring with a mental health diagnosis as an alternative to costly out of state facility based neurobehavioral rehabilitation, hospitalization, institutionalization, incarceration or homelessness The department has been funding these services through exception to policy while administrative rules were being developed with a stakeholder group representing brain injury professionals. These services yield a costs savings to the state for members who would have otherwise been admitted to out of state facility based services for neurobehavioral rehabilitation.

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

   This rule will formally implement community-based neurobehavioral rehabilitation services as a Medicaid covered benefit for adults who have a brain injury and meet the service criteria. Providers will no longer need an exception to policy to provide the service.

   Members will also be able to access this service as an alternative to out of state care.

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

   This service assists with Olmstead decision and the Americans with Disabilities Act by providing a community based alternative to expensive institutional care for members needing intensive neurobehavioral rehabilitation. .

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?

   Eligible Medicaid members meeting the service criteria will have the opportunity to receive community based neurobehavioral rehabilitation services as an alternative to costly out of state facility based neurobehavioral rehabilitation as well as receive

intermittent services to prevent hospitalization, institutionalization, incarceration or homelessness and to assist the member and their caregivers to implement compensatory strategies in the home that enable the member to remain in their own home.

7. What are the potential benefits of this rule?

   Eligible Medicaid members will have the opportunity to receive community-based neurobehavioral rehabilitation within the state of Iowa rather than more costly out of state facility based rehabilitation. Members and their families in the community may access the hourly CNR service to receive training and support to maintain the qualified Medicaid member in their own home with the intent of preventing institutionalization, hospitalization, incarceration or homelessness.

   Providers will no longer need to request an exception to policy to provide the services. Once the service is formally in rule, it is likely that more providers will be interested in enrolling to provide the service.

   Providers of BI Waiver services, members and their family members and caregivers will have assistance available from qualified brain injury professionals to assist members to successfully transition back into their own homes as well as support and assistance to implement compensatory strategies and behavioral support plans in the member's home with the intent of members being able to remain in their own home.

   This services results in an average costs savings to the state of $33,696.47 per member per year over those members who are served in out of state neurorehabilitation facilities.

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

   The locations where the CNRS residential services are provided are licensed by the Department of Inspections and Appeals as a Residential Care Facility, to include those under special license in accordance with Iowa Code 135c, and shall be considered a "family home" in compliance with 2009 Iowa Code 414.22 DIA has licensed four such locations to date. The cost to DIA is the cost of staff resources for the home licensure.

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

   The locations where the CNRS residential services are provided are licensed by the Department of Inspections and Appeals as a Residential Care Facility, to include those under special license in accordance with Iowa Code 135c, and shall be considered a "family home" in compliance with 2009 Iowa Code 414.22.

   CARF accredits the CNRS programs for residential rehabilitation programs and brain injury specialty program for adults

10. What alternatives to direct regulation in this area are available to the agency? Why were other alternatives not used?
The program could continue to operate through an exception to policy process; however that would not assure that the service continues to be funded through Medicaid and discourages other providers from enrolling to deliver this service.

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

No the department has a process for requesting exception to policy in rule and any member or provider may request an exception in accordance to 441 IAC Chapter 107

12. What are the likely areas of public comment?

These rules have been developed in partnership with the brain injury community over a period of several years and the service has yielded positive results for members who have had the opportunity to receive the service through exception to policy. Likely areas of comment will pertain to staff qualifications and training requirements some may comment that the requirements are too high, while other may request that additional training requirements be added.

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)

The impact on private sector jobs will be positive as jobs are created as new locations and providers are developed. It is difficult to project where providers will develop these services. Current locations include Des Moines, Iowa City, and due to the current wait list for services, additional locations will open in the spring and summer 2015 in Coralville, Dewitt and Ankeny.

Administrative Rule Fiscal Impact Statement

Date: July 23, 2015

Agency: Human Services

IAC citation: 441 IAC

Agency contact: LeAnn Moskowitz

Summary of the rule:

Adds the Community Based Neurobehavioral Rehabilitation services as a covered benefit under the Medicaid State Plan.

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.

_X_ Fiscal impact cannot be determined.

Brief explanation:

This rule change will add community-based neurobehavioral rehabilitation services as a covered benefit under Medicaid. Currently this service is paid through the exception to policy (ETP) process. Once the service is formally in rule, it is likely that more providers will be interested in enrolling to provide the service.

The fiscal impact resulting from this potential expansion will be dependent on the situation of the individuals accessing services. The daily rate for these services is expected to be between $550 and $650 and the average length of stay is expected to be nine to twelve months. Some out-of-state facilities have a daily rate in excess of $900. The average daily rate for Iowa Medicaid nursing facilities is approximately $160 and the daily rate for ICF/IDs (excluding resource centers) ranges from $300 to $400. If an individual moves from a higher cost out-of-state facility, there will be savings. If an individual moves from a lower cost institutional or community setting, there will be additional costs.

As of March 2015, there were ten individuals accessing services at one community-based neurobehavioral rehabilitation provider. Seven of these individuals enrolled during calendar year 2014 and for these seven individuals, the department pulled expenditures to determine the average monthly Medicaid cost both before and after the services began. Below is a summary of this analysis.

Member	Out-of-State Prior to Admission?	Avg. Monthly Medicaid Cost Prior to Admission	Avg. Monthly Medicaid Cost After Admission	Net Monthly Cost/(Savings)	Net Annual Cost/(Savings)
Member 1	No	$7,865.21	$22,068.99	$14,203.79	$170,445.47
Member 2	No	$4,843.23	$18,875.08	$14,031.85	$168,382.25
Member 3	Yes	$28,143.02	$18,224.05	($9,918.97)	($119,027.59)
Member 4	No	$2,616.42	$19,972.14	$17,355.72	$208,268.68
Member 5	No	$738.05	$18,605.41	$17,867.36	$214,408.29
Member 6	Yes	$29,107.80	$18,481.10	($10,626.70)	($127,520.39)
Member 7	No	$5,138.25	$19,263.62	$14,125.37	$169,504.44
			Total	**$57,038.43**	**$684,461.15**

Of the seven participants, two transitioned from higher cost out-of-state settings and five transitioned from lower cost settings. While this analysis shows a net cost increase, it does not attempt to predict what might have happened to these five participants had these services not been available. It is possible that absent these services, these individuals would have moved to even higher cost settings (out-of-state, inpatient hospital, incarceration). It is also not known what impact these services will have on longer-term health outcomes and cost. Higher short-term costs for these services could potentially lead to improved health outcomes and lower long-term costs. For these reasons the fiscal impact cannot be determined.

While the fiscal impact is not known, there is the potential for additional spending if individuals transition into this service from lower cost settings. This risk may increase as the number of providers and beds increases.

Note: The above analysis only addresses residential services. Intermittent services are not currently reimbursed by Iowa Medicaid so there is no historical data available to determine the fiscal impact.

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. Cost Savings

Assumptions:

Describe how estimates were derived:

Estimated Impact to the State by Fiscal Year		
	Year 1 (SFY16)	**Year 2 (SFY17)**
Revenue by each source:		
General fund		
Federal funds		
Other (specify):		
TOTAL REVENUE		
Expenditures:		
General fund		
Federal funds		
Other (specify):		
TOTAL EXPENDITURES		
NET IMPACT	Unknown	Unknown

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

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

_X_ Funding has not been provided for the rule.
This rule change results in a cost savings to the state.
Any cost increase will increase the SFY16 Medicaid unfunded need.

Fiscal impact to persons affected by the rule:

Eligible Medicaid members will have the opportunity to receive community-based neurobehavioral rehabilitation within the state of Iowa rather than more costly out of state facility based rehabilitation. Members and their families in the community may access the hourly CNR service to receive training and support to maintain the qualified Medicaid member in their own home with the intent of preventing institutionalization, hospitalization, incarceration or homelessness.

Providers will no longer need to request an exception to policy to provide the services. Once the service is formally in rule, it is likely that more providers will be interested in enrolling to provide the service.

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

No impact is anticipated.

Agency representative preparing estimate: Joe Havig

Telephone number: 515-281-6022

Comments and Responses on ARC 2113C
Human Services Department
Rules 441—77.52, 78.55, 79.1(2), 79.1(28), and 79.3(2)"d"(42)
Received September 8, 2015

The following persons/organizations provided written comments, which are included iin the summary below:
1. Geoffrey Lauer, Executive Director, Brain Injury Alliance of Iowa
2. Julie Fidler Dixon, Executive Director, On With Life

COMMENT 1: Both respondents, stated that the Department should add "formal fire prevention and reaction training on a regular basis" to paragraph 77.52(3)"c".

DEPARTMENT RESPONSE 1: The Department agreed with the comment and will amend paragraph 77.52(3)"c" as follows:
c. Within 30 days of commencement of direct service provision employees shall complete Cardio Pulmonary Resuscitation (CPR) Training, a First Aid course, Fire Prevention and Reaction Training and Universal Precautions Training. These training courses shall be completed no less than annually.

COMMENT 2: The respondent stated that the Department should add that the member should participate in the evaluation of their progress towards treatment goals to subparagraph 77.52(3)"k"(3). The reference to the evaluation of progress towards treatment goals is implied in the section above regarding development of the individualized service plan (ISP) but appears to have been omitted in this section. The reference to the evaluation of progress towards treatment goals must be here to assure person-centered focus.

DEPARTMENT RESPONSE 2: The Department agreed with the comment and will amend subparagraph 77.52(3)"k"(3) as follows:
(3) The member and their treatment team evaluate the members' progress towards treatment goals ~~is evaluated~~ regularly and no less than quarterly. Treatment plans are reviewed regularly and are revised as the member's status or needs change to reflect the member's progress and response to treatment, but no less than quarterly

COMMENT 3: The respondent stated that any restraint, particularly one of a chemical nature, must be in accordance with a prescription, regular oversight, and support of a licensed medical professional in subparagraph 77.52(3)"k"(5). Overall the language about the use of retreating is outdated and not in accordance with best practice of positive behavioral supports. The language should be brought into accordance with best practice in this area.

DEPARTMENT RESPONSE 3: The homes where the residential community-based neurobehavioral rehabilitation services are provided are licensed as Residential Care

Facilities with specialized license for three- to five-beds under Iowa Administrative Code 481--63.47. These administrative rules address resident's rights and the use of least restrictive interventions. The Department agreed with the comment and will amend subparagraph 77.52(3)"k"(5) as follows:
(5) When a member requires any restrictive interventions the interventions will be implemented in accordance with Iowa Administrative Code, subrule 481—63.23(4), rule 481—63.33, and rule 481—63.37. When a member has a guardian or legal representative that person will provide informed consent to treat and provide informed consent for any restrictive interventions that may be required to protect the health or safety of the member. Restrictive interventions include but are not limited to:

COMMENT 4: Both respondents stated that there is an error in the sentence found in subparagraph 78.56(2)"b"(2). "OTHER THAN" should read instead as "INCLUSIVE OF".

DEPARTMENT RESPONSE 4: The Department agreed with the comment from the respondent. Subparagraph 78.56(2)"b"(2) will be amended as follows:
(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care ~~other than hospitalization, institutionalization, incarceration or homelessness. treatment~~ more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or in-patient hospitalization)

COMMENT 5: The respondent stated that subparagraph 77.52(3)"a"(6) does not specify how competency in performing assigned duties and interacting with members will be assessed.

DEPARTMENT RESPONSE 5: Providers have expressed that it is the providers that are best qualified to determine which methodologies are most useful in assessing the competency of the direct care personnel. The Department does not prescribe specific methodologies of personnel competency assessment for other Medicaid services and will continue to expect that the providers will determine the best methods of assessing the competency of their direct care personnel that is most appropriate for their individual organizations. The Department will not amend the proposed rulemaking in response to this comment.

COMMENT 6: The respondent commented that the mention of chemical restraint as a restrictive intervention which may be required does not specify how or by whom such a restraint may be prescribed, and implies that it is something imposed by the program in subparagraph 77.52(3)"k"(5). In addition, no parameters are noted for the use of any restraints and no staff training is required relative to the implementation of manual or mechanical restraints. Further, no mention is made of what type of professional must approve such a plan and how it is to be monitored. Rules governing more institutional levels of care (SNF, ICF, RCF) require that measures used must be the "least restrictive", surely any restraint measures used in a community-based setting should include this language and include strict controls as to their use, if allowed at all.

DEPARTMENT RESPONSE 6: The Department agreed with the respondent and believes that the proposed changes to the amendments found in Department Response 3 above addresse this comment.

COMMENT 7: The subparagraphs 78.56(2)"b"(1) and (2) note that "the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless; or is at risk of hospitalization, institutionalization, incarceration or homelessness" or has a history of such. This language does not specify that such treatment has occurred after the individual has sustained a brain injury, so individuals may qualify for this level of service by virtue of their behavior/symptomology unrelated to a brain injury; consequently, many individuals will qualify for this level or service by their premorbid history which we do not believe was the intent of the legislature, Iowa Medicaid Enterprise (IME), or the provider work group focused on the development of these rules.

DEPARTMENT RESPONSE 7: The Department stated that in order to be eligible for Community-based Neurobehavioral Rehabilitation Services (CNRS) services, the member must have brain injury diagnosis as set forth in rule 441--83.81. For the purposes of clarity paragraph 78.56(2)"b" will be amended as follows:
b. Risk factors. The member has the following <u>post brain injury</u> risk factors:

Rossander, Harry V

From:	no-reply@iowa.gov
Sent:	Tuesday, September 08, 2015 2:38 PM
To:	Policy Analysis
Cc:	jdixon@onwithlife.org
Subject:	Public Comment Received on ARC 2113C

A new public comment has been received on **ARC 2113C**. The comment and contact information are listed below.

Comment

1. 77.52(3).a.(6) This section does not specify how competency in performing assigned duties and interacting with members will be assessed. 2. 77.52(3).c. It seems essential that fire prevention and response training be added to this section. 3. 77.52(3).k.5.1. The mention of chemical restraint as a restrictive intervention which may be required does not specify how or by whom such a restraint may be prescribed, and implies that it is something imposed by the program. In addition, no parameters are noted for the use of any restraints and no staff training is required relative to the implementation of manual or mechanical restraints. Further, no mention is made of what type of professional must approve such a plan and how it is to be monitored. Rules governing more institutional levels of care (SNF, ICF, RCF) require that measures used must be the "least restrictive", surely any restraint measures used in a community-based setting should include this language and include strict controls as to their use, if allowed at all. 4. 78.55(2).b.(1) and (2) These sections note that "the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless; or is at risk of hospitalization, institutionalization, incarceration or homelessness" or has a history of such (see comment #5). This language does not specify that such treatment has occurred after the individual has sustained a brain injury, so individuals may qualify for this level of service by virtue of their behavior/symptomology unrelated to a brain injury; consequently, many individuals will qualify for this level or service by their premorbid history which we do not believe was the intent of the legislature, IME or the provider work group focused on the development of these rules. 5. 78.55(2)b.(2) It appears that the term "other than" has been mistakenly used instead of "including" which is logical to the intent of the statement.

Contact Information

Name: **Julie Fidler Dixon**
Email: jdixon@onwithlife.org
Phone: **(515) 289-9613**

Rossander, Harry V

From:	no-reply@iowa.gov
Sent:	Monday, August 24, 2015 2:32 PM
To:	Policy Analysis
Cc:	glauer@biaia.org
Subject:	Public Comment Received on ARC 2113C

A new public comment has been received on **ARC 2113C**. The comment and contact information are listed below.

The comment was made on paragraph **61**.

Document Content

c. Within 30 days of commencement of direct service provision, employees shall complete cardiopulmonary resuscitation (CPR) training, a first aid course, and universal precautions training.

Comment

I believe that the addition of formal fire prevention and reaction training on a regular basis should be added to these rules.

Contact Information

Name: **Geoffrey Lauer**
Email: glauer@biaia.org
Phone: **(319) 621-7078**

Rossander, Harry V

From: no-reply@iowa.gov
Sent: Monday, August 24, 2015 2:42 PM
To: Policy Analysis
Cc: glauer@biaia.org
Subject: Public Comment Received on ARC 2113C

A new public comment has been received on **ARC 2113C**. The comment and contact information are listed below.

The comment was made on paragraph **79**.

Document Content

(3)The member's progress towards treatment goals is evaluated regularly and no less than quarterly. Treatment plans are reviewed regularly, but not less than quarterly, and are revised as the member's status or needs change to reflect the member's progress and response to treatment.

Comment

The member should participate in the evaluation of their progress towards treatment goals. This is implied in the section above regarding development of the ISP BUT appears to have been omitted in this section and must be here to assure person centered focus.

Contact Information

Name: **Geoffrey Lauer - BIA_Iowa**
Email: glauer@biaia.org
Phone: **(319) 621-7078**

Rossander, Harry V

From: no-reply@iowa.gov
Sent: Monday, August 24, 2015 2:46 PM
To: Policy Analysis
Cc: glauer@biaia.org
Subject: Public Comment Received on ARC 2113C

A new public comment has been received on **ARC 2113C**. The comment and contact information are listed below.

The comment was made on paragraph **82.**

Document Content

1.Restraint, including chemical restraint, manual restraint or mechanical restraint;

Comment

Any restraint, particularly one of a chemical nature, must be in accordance with the prescription, regular oversight, and support of a licensed medical professional. Overall this language with regards to the use of retreating is outdated and not in accordance with best practice of positive behavioral supports. It should be reviewed to bring into accordance with best practice in this area.

Contact Information

Name: **Geoffrey Lauer - BIA-Iowa**
Email: glauer@biaia.org
Phone: **(319) 621-7078**

Rossander, Harry V

From:	no-reply@iowa.gov
Sent:	Monday, August 24, 2015 3:08 PM
To:	Policy Analysis
Cc:	glauer@biaia.org
Subject:	Public Comment Received on ARC 2113C

A new public comment has been received on **ARC 2113C**. The comment and contact information are listed below.

The comment was made on paragraph **111**.

Document Content

(2)The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care other than hospitalization, institutionalization, incarceration or homelessness.

Comment

I believe there is an error in this sentence. "OTHER THAN" should read instead as "INCLUSIVE OF". If we exclude hospitalization, institutionalization, incarceration or homelessness from than we allow for "counseling", or other lesser intensive professional supportive services. Not that I am opposed to that. However I do not believe that this is the intent of the workgroup.

Contact Information

Name: **Geoffrey Lauer - BIA-Iowa**
Email: glauer@biaia.org
Phone: **(319) 621-7078**